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

OPEN SESSION

OCTOBER 12, 2011

DAY 1

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 1 -- OCTOBER 12, 2011

Regular session of the meeting of the State of Illinois Health Facilities and Services Review Board was held on October 12 & 13, 2011, at the Bolingbrook Golf Club, 2001 Rodeo Drive, Bolingbrook, Illinois.

1 PRESENT:

2 Dale Galassie - Chairman

3 Ronald Eaker

4 John Hayes

5 John Burden

6 Alan Greiman

7 Kathy Olson

8 Richard Sewell

9 Rob Hilgenbrink

10

ALSO PRESENT:

11 Courtney Avery - Administrator

12 Cathy Clarke - Assistant

13 Frank Urso - General Counsel

Juan Morado - Assistant Counsel

14

Michael Constantino - IDPH Staff

15

Bill Dart - IDPH Staff

16

Claire Berman - IDPH Staff

17

David Carvalho - Deputy Director, IDPH

18

Michael C. Jones - IDFS

19

20

21

Reported by:

22 Karen K. Keim

CRR, RPR, CSR-IL, CRR-MO

23 Midwest Litigation Services

401 N. Michigan Avenue

24 Chicago, IL 60611

1 START TIME: 10:06 a.m.

2

3 CHAIRMAN GALASSIE: Good morning, ladies and
4 gentlemen, and welcome. We hope you'll be comfortable here
5 this morning. It's a beautiful day.

6 Let me start out by welcoming a class we have
7 here -- I'm not sure if it's undergraduate or graduate --
8 from Governor State University, a planning class. If
9 anyone is here, would you rise, any students, please.

10 (Applause)

11 CHAIRMAN GALASSIE: Welcome here. You'll see
12 government in action today, hopefully. That's our plan.

13 Okay. I will ask to call the meeting to order and ask
14 for a roll call by Staff, please.

15 MR. DART: Chairman Galassie?

16 CHAIRMAN GALASSIE: Here.

17 MR. DART: Member Hayes?

18 MR. HAYES: Here.

19 MR. DART: Dr. Burden?

20 MR. BURDEN: Here.

21 MR. DART: Mr. Eaker?

22 MR. EAKER: Present.

23 MR. DART: Justice Greiman?

24 MR. GREIMAN: Here.

1 MR. DART: Mr. Hilgenbrink?

2 MR. HILGENBRINK: Here.

3 MR. DART: Ms. Olson?

4 MS. OLSON: Here.

5 MR. DART: Mr. Penn?

6 (No response)

7 MR. DART: Mr. Sewell?

8 MR. SEWELL: Here.

9 CHAIRMAN GALASSIE: For the record, Mr. Penn
10 advised us he would not be present today.

11 MR. DART: That's eight answering.

12 CHAIRMAN GALASSIE: Thank you.

13 Can I have a motion to approve the agenda,
14 with a subsequent roll call vote, please?

15 MS. OLSON: So moved.

16 MR. SEWELL: Second.

17 CHAIRMAN GALASSIE: Moved and seconded. Roll
18 call.

19 MR. DART: Chairman Galassie?

20 CHAIRMAN GALASSIE: Here -- yes. Sorry.

21 MR. DART: Member Hayes?

22 MR. HAYES: Yes.

23 MR. DART: Dr. Burden?

24 MR. BURDEN: Yes.

1 MR. DART: Mr. Eaker?

2 MR. EAKER: Yes.

3 MR. DART: Justice Greiman?

4 MR. GREIMAN: Yes.

5 MR. DART: Mr. Hilgenbrink?

6 MR. HILGENBRINK: Yes.

7 MR. DART: Ms. Olson?

8 MS. OLSON: Yes.

9 MR. DART: Mr. Sewell?

10 MR. SEWELL: Yes.

11 CHAIRMAN GALASSIE: Minutes are approved.

12 Thank you. Motion passes. That was the agenda. I'm

13 sorry.

14 We'll move to approval of the minutes. I will

15 need a motion to approve the minutes.

16 MR. EAKER: So moved.

17 MR. HAYES: Second.

18 CHAIRMAN GALASSIE: Moved and seconded. Any

19 corrections?

20 (Pause)

21 CHAIRMAN GALASSIE: Hearing none, roll call.

22 MR. DART: Chairman Galassie?

23 CHAIRMAN GALASSIE: Yes.

24 MR. DART: Mr. Hayes?

1 MR. HAYES: Yes.

2 MR. DART: Dr. Burden?

3 MR. BURDEN: Yes.

4 MR. DART: Mr. Eaker?

5 MR. EAKER: Yes.

6 MR. DART: Justice Greiman?

7 MR. GREIMAN: Yes.

8 MR. DART: Mr. Hilgenbrink?

9 MR. HILGENBRINK: Yes.

10 MR. DART: Ms. Olson?

11 MS. OLSON: Yes.

12 MR. DART: Mr. Sewell?

13 MR. SEWELL: Yes.

14 CHAIRMAN GALASSIE: Bill, I think Roberts

15 Rules dictate that the Chairman's vote be last.

16 Post-Permits approved by the Chairman, Mr.

17 Constantino?.

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

19 CHAIRMAN GALASSIE: Thank you.

20 MR. CONSTANTINO: Number one, Project No.

21 08-082, Victorian Village, to establish a 50-bed, long-term

22 care facility. Permit renewed to 12/31/2012. Approved by

23 the chairman August 30th, 2011.

24 Fresenius Medical Care, Hoffman Estates,

1 approved to add 3 ESRD stations to a 17-station facility,
2 for a total of 20 ESRD stations, at a cost of \$317,000.
3 approved August 30th, 2011.

4 Project 08-078, South Loop Endoscopy and
5 Wellness Center, to establish a limited specialty ASTC.
6 Extension of the obligation period for 12 months approved,
7 September 27th, 2011.

8 Thank you, Mr. Chairman.

9 CHAIRMAN GALASSIE: Thank you, Michael.

10 Next we will move to the public comment of
11 this morning's agenda, and we have several folks, I
12 believe, who have signed up to make comment. We will call
13 two or three names off, if you can cue up to come up to the
14 microphone.

15 CHAIRMAN GALASSIE: Mr. Pedro Anaya, a
16 concerned citizen.

17 Folks, you do understand the rules that we try
18 to abide by for everyone's time and respect is a maximum of
19 three minutes. If I have to hit the gavel, I do so
20 respectfully, but I will ask you to finish within three
21 minutes. We'll give you a one-minute warning.

22 Juan, if you will be time keeper for us.

23 That does not try to diminish your comments
24 but to give everyone an opportunity to make comments within

1 our 30-minute time frame -- 3-minute time frame.

2 MR. ANAYA: Good morning. First I'd like to
3 thank the Board for allowing us to be here and present our
4 thoughts and concerns about the facility. I'd like to
5 begin by letting you know my thoughts and concerns are
6 mainly that as a concerned citizen and also as a person
7 whose family members also are suffering from kidney
8 diseases and are needing these types of facilities.

9 CHAIRMAN GALASSIE: I'm actually going to
10 have to interrupt. I'm sorry.

11 (Pause)

12 CHAIRMAN GALASSIE: Our record shows that
13 you're here to discuss the configuration of the Board and
14 not a specific application.

15 MS. AVERY: The applications will come after
16 that. You wanted to present on a letter that you published
17 to the Editor of the Sun Times about the lack of
18 representation on the Board.

19 MR. ANAYA: Actually --

20 MS. AVERY: Is there something from your
21 organization? I talked to you guys about --

22 CHAIRMAN GALASSIE: If we have it confused,
23 we apologize. Your comments should be made right when the
24 application comes before the Board, if it's application

1 specific.

2 MS. AVERY: I thought you were the
3 spokesperson. So, the spokesperson should come forward.
4 The representation from -- representative from your
5 organization should speak. There was a letter that was
6 published regarding the configuration of the Board and a
7 lack of a Hispanic or Latino person to sit on the Board,
8 and this morning I had a conversation with representatives
9 from your organization who wanted to speak about that in
10 the public participation comment section. So, if that
11 person would come forward, we would appreciate it. And the
12 same rules apply.

13 MR. URSO: So this gentleman will be called
14 again, correct?

15 MR. ANAYA: I'm sorry. I was actually -- I
16 didn't want to talk about the configuration but more about
17 the leadership. But I'm not the one that published the
18 letters to the Editor. I just wanted to make that clear.

19 (Pause)

20 CHAIRMAN GALASSIE: Good morning. Thank you.
21 We apologize for the confusion.

22 MR. RANGEL: Good morning members of the
23 Board. My name is Juan Rangel. I'm the CEO of UNO, United
24 Neighborhood Organization. The organization has been

1 around for 27 years, working in metropolitan Chicago.

2 The Hispanic -- as you know, the Hispanic
3 population is one of the fastest-growing demographics in
4 the country. In Illinois, it is the second largest
5 population, making up 16 percent of the State's total
6 residents. The Latinos are also at a higher risk of
7 developing serious diseases.

8 I'm here today because I believe that the lack
9 of representation of the Hispanic community on this Board
10 and the existing need formula on -- is having a detrimental
11 impact on the access to healthcare available to the
12 Hispanic community. This rapid growth means that Hispanics
13 with end stage renal disease are likely to represent an
14 ever increasing portion of the total population with ESRD.
15 I applaud this Board and its members for the important work
16 it has done to ensure Illinois residents have the access
17 they need to healthcare. We are troubled, however, that
18 the State -- our State has not appointed members that fully
19 represent the diverse Illinois residents it is intended to
20 serve. While the members of this Board hold the highest
21 qualifications, we believe it is also in our community's
22 detriment that the Latino community is not represented by a
23 Hispanic board member.

24 The Hispanic population is more at risk when

1 it comes to the most serious diseases. We are twice as
2 likely to develop certain diseases, including hypertension
3 and diabetes, according to a recent CDC study. In
4 particular, chronic kidney disease, which leads to end
5 stage renal disease, where dialysis is required
6 disproportionately impacts Hispanic. That phenomena is not
7 going away. A report just released by the CDC predicts
8 that diabetes in metropolitan Chicago will increase by 50
9 percent in the next 15 years, and the study shows that
10 where the population is largely Latino, the demand for
11 services like healthcare education often exceeds the
12 capacity to supply them.

13 Also, as Baby Boomers age and live longer,
14 their chances of needing dialysis increases. Our concern
15 is that station will be fully used by the older population
16 and it will push out Hispanics and limit our access. I am
17 also concerned that this need is not being met because of
18 the way the Board and the Illinois Department of Public
19 Health estimate the need for dialysis stations. Clearly,
20 demographics have an impact on dialysis health facilities
21 in planning areas. Without adjusting the need formula to
22 reflect this reality, the State is not adequately serving
23 the Hispanic community.

24 So, therefore, we're here in request of this

1 Board, but also as a statement to the State's leadership,
2 that Hispanics be considered for representation on this
3 Board. Thank you.

4 CHAIRMAN GALASSIE: Thank you, Mr. Rangel. I
5 think I can speak for the Board that certainly we are in
6 strong support of your interests, and, of course, you
7 realize we don't have the authority to make appointments to
8 our own Board. But your comments are certainly appropriate
9 for the record. Thank you.

10 All yours, sir.

11 MR. ANAYA: Thank you. Just to touch a little
12 bit with Mr. Rangel, I am in agreement. Definitely we need
13 more representation on the Board, and even though this
14 Board is appointed, I'd like to make it known to hopefully
15 downstate that they may find the proper people that are
16 available to sit with the Board and represent, because of
17 the growing population of diabetes in our -- within our
18 ethnicity. Pretty much all of my thoughts are in agreement
19 with what Mr. Rangel read, and I would just like the Board
20 to consider the thought of having more leadership that
21 would represent that the numbers are growing higher and
22 higher.

23 Thank you for your time, and I appreciate it.

24 CHAIRMAN GALASSIE: Thank you, and again we

1 appreciate your comments.

2 MS. AVERY: For public comment on Project
3 11-024, we have testimony to oppose. Bryan Brandenburg of
4 Westchester, Illinois.

5 CHAIRMAN GALASSIE: Good morning, sir.
6 Public participation we won't be swearing in.

7 MR. BRANDENBURG: Good morning. My name is
8 Brian Brandenburg, and I am a Regional Vice-President for
9 Fresenius Medical Care.

10 We're not opposing this project on the basis
11 of need. However, we are concerned about inaccuracies in
12 the application. For example, U.S. Renal avoids the Boards
13 need and access criteria by claiming Fresenius admission
14 policies do not allow patients to dialyze near their home.
15 They give three alleged examples of restrictive admissions.
16 Two examples were misrepresented with factual admissions,
17 and the third was an unknown example.

18 Fresenius records show that these physicians
19 admitted 79 new ESRD patients in the past three and a half
20 years to Fresenius facilities throughout Chicagoland. The
21 projected referrals of 147 patients to the Oak Brook
22 facility, a total of 277 if you combine the Bolingbrook and
23 Streamwood projects, are not consistent with the past three
24 years' historical referrals, which averaged 23 per year.

1 One of the reasons their calculations are not accurate is
2 that 40 percent of the patients listed in the historical
3 referral data were referred to nursing homes, home dialysis
4 programs, and as inpatients at hospitals. While the
5 Board's rules do not prohibit listing these types of
6 referrals, the numbers do not reflect referral trends for
7 in-center dialysis clinics.

8 We also note that Doctors Rauf and Ahmed are
9 also listed -- also listed historical referrals to three
10 Fresenius facilities, Bartlett, Palos and (inaudible), that
11 do not exist. Dr. Rauf stated that the towns of Downers
12 Grove and Hinsdale and Oak Brook are in need of dialysis
13 due to high Hispanic and African American population.
14 Based on the 2010 U.S. census, 3.5 percent of Hinsdale is
15 Hispanic and 1.3 is African American. 4.3 percent of Oak
16 Brook is Hispanic, and 2 percent is African American, and
17 at Downers Grove, 5.2 percent is Hispanic and 3.4 percent
18 is African American. These are hardly overwhelming
19 statistics.

20 U.S. Renal alleges Fresenius has a broad
21 market share that restricts patients from choice of
22 providers. There is nothing in the Board's rules that
23 require us to look at choice of providers in its decision
24 making.

1 In sum, we encourage the Board to look at the
2 referral information provided by U.S. Renal to support the
3 proposed Oak Brook facility carefully, as we do not believe
4 these physicians have a patient base to support it. We
5 also request the Board discourage applicants from making
6 misleading and even inaccurate statements about other
7 providers, as opposed to simply addressing the relevant
8 criteria this Board bases its decision on.

9 CHAIRMAN GALASSIE: Thank you.

10 We will be attempting to bring public comment
11 to the specific item as that applicant comes forward, as
12 opposed to just generically.

13 Moving on. Moving on to Permit Renewal
14 Requests. Item No. 09-019, Elmhurst Medical and Surgical
15 Center.

16 Good morning. If you would introduce yourself
17 and spell your name for the reporter, and then we'll have
18 you sworn in, please.

19 MR. MARCKEL: My name is Greg Marckel (spelled
20 name). I am the architect for the facility.

21 (Oath given.)

22 CHAIRMAN GALASSIE: Staff, please.

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

24 In January 2010, the State Board approved

1 Project 09-019. The permit authorized establishment of a
 2 limited specialty ASTC in Elmhurst, Illinois. The total
 3 estimated project cost was approximately \$560,000. This
 4 project is obligated and is approximately 98 percent
 5 complete. The State Board Staff notes this is the third
 6 permit renewal request for this project. The permit
 7 holders are now requesting a project completion date of
 8 March 31st, 2012. The reason given for the permit renewal
 9 request is that the applicants, or the permit holders,
 10 state that IDPH licensure requested change to the facility.

11 Thank you, Mr. Chairman.

12 CHAIRMAN GALASSIE: Thank you.

13 Comments for the Board, sir?

14 MR. MARCKEL: The original project was --
 15 completion was April 22nd. We had our IDPH design
 16 standards inspection in June 22nd. They came out and
 17 requested that we add some additional fire doors to the
 18 existing building, and there was also some clarification of
 19 some existing facility construction types. We have since
 20 received our design standards unit approval as of October
 21 3rd, and now we are just waiting to go in to our nursing
 22 licensure final approval, and then we'll submit it to the
 23 CON.

24 CHAIRMAN GALASSIE: Mike, there is no

1 opposition to this?

2 MR. CONSTANTINO: No, sir.

3 CHAIRMAN GALASSIE: Questions from the Board?

4 (Pause)

5 CHAIRMAN GALASSIE: Hearing none, I'll ask
6 for a motion to renew Permit 09-019, Elmhurst Medical and
7 Surgical Center.

8 MR. EAKER: So moved.

9 MR. SEWELL: Second.

10 CHAIRMAN GALASSIE: Motion and seconded by --

11 MR. DART: Motion made by Mr. Eaker, seconded
12 by Mr. Sewell. Roll call. Dr. Burden?

13 MR. BURDEN: Yes.

14 MR. DART: Mr. Eaker?

15 MR. EAKER: Yes.

16 MR. DART: Justice Greiman?

17 MR. GREIMAN: Yes.

18 MR. DART: Mr. Hayes?

19 MR. HAYES: Yes.

20 MR. DART: Mr. Hilgenbrink?

21 MR. HILGENBRINK: Yes.

22 MR. DART: Ms. Olson?

23 MS. OLSON: Yes.

24 MR. DART: Mr. Sewell?

1 MR. SEWELL: Yes.

2 MR. DART: Chairman Galassie?

3 CHAIRMAN GALASSIE: Yes.

4 MR. DART: That's 8 to 0.

5 CHAIRMAN GALASSIE: Motion passes. Thank you
6 very much. Good luck.

7 Moving on to Item 09-063 Roseland Community
8 Hospital.

9 Good morning.

10 MS. PAIGE: Good morning.

11 CHAIRMAN GALASSIE: Introduce, spell your
12 name for the Recorder, and we'll swear you in.

13 MS. PAIGE: All right. Good morning. My name
14 is Billie Paige. I am the CON consultant for Roseland
15 Community Hospital. (Spells name)

16 (Oath given)

17 CHAIRMAN GALASSIE: Staff report.

18 MR. CONSTANTINO: Thank you, Mr. Chairman. In
19 April 2010, the State Board approved Project 09-063. The
20 permit authorizes establishment of a 30-bed acute mental
21 illness category of service at Roseland Community Hospital
22 in Chicago. This project is not obligated, and the current
23 project completion date is October 31st, 2011. Total
24 estimated project cost is approximately \$3.5 million. This

1 is the second permit renewal request for this project. The
2 permit holders are requesting a project completion date of
3 April 30th, 2012. The reason for the delay, the permit
4 holder states that the initial IDPH Life Safety Survey that
5 occurs in advance has not been completed, which could take
6 up to 60 additional days to complete.

7 CHAIRMAN GALASSIE: Thank you.

8 Any comments for the Board?

9 MS. PAIGE: Just one comment from the Staff
10 report. I must apologize to the Board. I had thought that
11 the hospital had sent in a Notice of Obligation. I will
12 make sure that that is done right away.

13 CHAIRMAN GALASSIE: Thank you.

14 Any questions from the Board members for the
15 representative?

16 (Pause)

17 CHAIRMAN GALASSIE: Hearing none, I will
18 entertain a motion to renew Permit 09-063 for Roseland
19 Community Hospital.

20 MR. BURDEN: So moved.

21 MR. HILGENBRINK: Second.

22 CHAIRMAN GALASSIE: Moved and seconded. Roll
23 call, please.

24 MR. DART: Motion made by Dr. Burden, seconded

1 by Mr. Hilgenbrink.
2 Dr. Burden?
3 MR. BURDEN: Yes.
4 MR. DART: Mr. Eaker?
5 MR. EAKER: Yes.
6 MR. DART: Justice Greiman?
7 MR. GREIMAN: Yes.
8 MR. DART: Mr. Hayes?
9 MR. HAYES: Yes.
10 MR. DART: Mr. Hilgenbrink?
11 MR. HILGENBRINK: Yes.
12 MR. DART: Ms. Olson?
13 MS. OLSON: Yes.
14 MR. DART: Mr. Sewell?
15 MR. SEWELL: Yes.
16 MR. DART: Chairman Galassie?
17 CHAIRMAN GALASSIE: Yes.
18 MR. DART: That's 8 to 0.
19 CHAIRMAN GALASSIE: Motion passes.
20 MS. PAIGE: Thank you.
21 CHAIRMAN GALASSIE: You're welcome. Good
22 luck.
23 Moving on to Item 6-B, Extension Requests, we
24 have none.

1 Item 6-C, Exemption Requests, we have none.

2 Item 6-D is No. 08-086. Representatives from
3 Springfield Nursing and Rehab Center, would please come
4 forward. Again, if you would introduce yourselves, spell
5 your names and be sworn in.

6 MR. FOLEY: Yes, thank you. My name is
7 Charles Foley (spells name), CON consultant.

8 MR. LEVINSON: Bryan Levinson (spells name),
9 representing the ownership and operator of Springfield
10 Nursing Center.

11 MR. GROGG: Edward Grogg (spells name),
12 President, Main Street Developer.

13 (Oath given)

14 CHAIRMAN GALASSIE: Thank you.

15 Staff report, please.

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

17 The permit holders were approved on April
18 21st, 2009 to construct a 75-bed, general, long-term care
19 facility in a total of approximately 54,370 gross square
20 feet of space in Springfield, Illinois. The cost of the
21 project is \$12.9 million. This project is not obligated,
22 and the project completion date is May 31st, 2013. The
23 permit holders are before you today to propose to reduce
24 the gross square footage of the project from 54,375 gross

1 square foot to 45,271 gross square foot, a decrease of
2 approximately 17 percent, with no reduction in cost.

3 Thank you, Mr. Chairman.

4 CHAIRMAN GALASSIE: Thank you, sir.

5 Good morning. Comments for the Board?

6 MR. FOLEY: Just very briefly, if I may.

7 First of all, I want to thank Staff for, obviously, their
8 positive review on this. There was no opposition to our
9 project either. We were in the process of wanting to sign
10 a construction contract on October the 1st, but we're
11 delaying that, obviously, until we get this approval today.
12 So, we are getting ready to sign the construction contract
13 here shortly. We have an open house planned for November
14 the 1st. So, we are planning to move along as fast as we
15 can in order to meet our deadline on this project.

16 So, with that, I would be more than glad to
17 answer any questions you may have.

18 CHAIRMAN GALASSIE: Thank you.

19 Questions by Board members?

20 (Pause)

21 CHAIRMAN GALASSIE: Hearing none, I guess I
22 have one, and I'm not sure who I am asking, but the square
23 footage was reduced?

24 MR. FOLEY: Yes, sir.

1 CHAIRMAN GALASSIE: But the price wasn't?

2 MR. FOLEY: Yes, sir.

3 CHAIRMAN GALASSIE: Can you help me
4 understand that?

5 MR. FOLEY: Of course. When this project went
6 out for bid, we did receive a cost. It came back extremely
7 high, over the 5 percent, obviously, and with that, it
8 would have, you know, killed the project by all means. So,
9 trying to save the project, we worked very hard to go back
10 to the drawing board, and to keep the cost the same, we was
11 able then to reduce the square footage. We took out the
12 basement, literally, and brought it upstairs. We kind of
13 reduced it a little bit overall upstairs, as well, but was
14 able to keep the cost, obviously, the same. I wanted to
15 say that we did, in fact, reduce costs, because our bids
16 were extremely high, and it was either to abandon the
17 project all together or to work within the parameters of
18 the permit amount as originally received, and that's
19 basically what we did, Mr. Galassie.

20 CHAIRMAN GALASSIE: So, you eliminated the
21 basement, so that square footage went?

22 MR. FOLEY: That square footage is gone.

23 CHAIRMAN GALASSIE: Price per square footage
24 remained the same?

1 MR. FOLEY: And the price per square footage.
2 we are in conformance, obviously, with the State standards.

3 MS. OLSON: I have a question. I'm confused
4 about what the status of the project is now. Have you
5 started the project?

6 MR. FOLEY: No. We've got the construction
7 architectural drawings, and everything has already been
8 submitted to Public Health, but actual turning the spade,
9 waiting for this approval before we do that.

10 MS. OLSON: But you're going to have an open
11 house next May?

12 MR. FOLEY: No, just ground breaking.

13 CHAIRMAN GALASSIE: Any other questions by
14 Board members?

15 (Pause)

16 MR. HILGENBRINK: Mr. Chairman, I have a
17 question.

18 How is the facility designed in terms of
19 sustainability efforts? Is there any LEED certification
20 for this facility?

21 MR. FOLEY: Thank you, sir. I'll let our
22 developer address that.

23 MR. GROGG: We have adopted several LEED
24 initiatives into the project. On the LEED project

1 checklist, there are 29 items of those items that have been
2 checked. We are not fully LEED certified, but there are 29
3 initiatives within that checklist that we're prepared to
4 institute.

5 MR. HILGENBRINK: Thank you.

6 CHAIRMAN GALASSIE: Any other questions?

7 (Pause)

8 CHAIRMAN GALASSIE: Hearing none, may I have a
9 motion to approve the alteration of Permit 08-086,
10 Springfield Nursing and Rehab Center?

11 MR. GREIMAN: So moved.

12 MR. BURDEN: Second.

13 MR. DART: Motion made by Justice Greiman,
14 second by Member Hayes.

15 Dr. Burden?

16 MR. BURDEN: Yes.

17 MR. DART: Mr. Eaker?

18 MR. EAKER: Yes.

19 MR. DART: Justice Greiman?

20 MR. GREIMAN: Yes.

21 MR. DART: Mr. Hayes?

22 MR. HAYES: Yes.

23 MR. DART: Mr. Hilgenbrink?

24 MR. HILGENBRINK: Abstain.

1 MR. DART: Ms. Olson?

2 MS. OLSON: Yes.

3 MR. DART: Mr. Sewell?

4 MR. SEWELL: Yes.

5 MR. DART: Chairman Galassie?

6 CHAIRMAN GALASSIE: Yes.

7 MR. DART: That's 7 votes in the affirmative.

8 CHAIRMAN GALASSIE: Motion passes.

9 Congratulations.

10 MR. HAYES: Excuse me. Just to make a change
11 there, Dr. Burden actually seconded the motion.

12 MR. DART: Okay. My mistake.

13 CHAIRMAN GALASSIE: Thank you, John.

14 Good luck.

15 I am moving on to Item No. 6-e, Declaratory
16 Rulings. I believe we have none.

17 Healthcare Worker Self-Referral Act, 6-F, I
18 believe we have none.

19 . And Status Reports on Conditional Contingent
20 Permits, Item 6-G, I believe we have none.

21 That brings us to 6-H, Applications Subsequent
22 to Initial Review. We will be calling 11-024, USRC Oak
23 Brook Dialysis, and if there is public comment, we'll start
24 with that. Do we have public comment?

1 MS. AVERY: Michael Cohan (spells name), in
2 support of the project.

3 CHAIRMAN GALASSIE: Introduce yourself and
4 spell your name, and we will swear you in, and we'll be
5 happy to hear your comments -- public participation, I'm
6 sorry, we don't need to swear you in.

7 MR. COHAN: Dr. Michael Cohan. I'm a
8 nephrologist in the western suburbs of Chicago and just
9 wanted to really affirm the need for more dialysis units
10 and dialysis spaces for the growing population of end-stage
11 renal disease in our community and feel that it would be
12 beneficial to have more options to patients that are going
13 to be requiring dialysis in the future, so they don't have
14 to travel long distances, or can be closer to their homes
15 when they need these important services.

16 CHAIRMAN GALASSIE: How long have you
17 practiced there, Doctor?

18 MR. COHAN: I've been practicing for 18 years.

19 CHAIRMAN GALASSIE: In that community?

20 MR. COHAN: I practice in Elmhurst currently.
21 I do not practice in the communities where these dialysis
22 units are going to be opening.

23 CHAIRMAN GALASSIE: I see. Thank you very
24 much.

1 Any questions from Board members?

2 (Pause)

3 CHAIRMAN GALASSIE: Hearing none, thank you.

4 MS. AVERY: Next we have Jennifer Linsner.

5 Following Jennifer is Kara Murphy. Following Kara Murphy
6 is Vickie Tulcus.

7 CHAIRMAN GALASSIE: Good morning. Welcome.

8 MS. LINSNER: Good morning. My name is
9 Jennifer Linsner (spells name). I am here today to support
10 U.S. Renal Care's application to build a dialysis center in
11 Oak Brook. I urge the Board to also support what is a
12 much-needed, critical project for dialysis patients in the
13 area, like me.

14 I've needed dialysis therapy since December,
15 when I became sick with a life-threatening illness. I feel
16 fortunate and grateful to have had Dr. Ahmed and Dr. Rauf's
17 care and compassion during this very difficult time. From
18 the beginning, they treated me with respect. They made me
19 feel well cared for. They discussed every step of my care.
20 They took the time to learn about me and my lifestyle.
21 They presented different treatment options and supported me
22 in making the right decision. They have always focused on
23 what I can do. When they knew how important it was for me
24 to get back to work full-time, they enabled me to do just

1 that. I have always felt valued as a patient in their
2 care. I will continue to see these talented doctors.

3 The dialysis treatment I received at
4 Fresenius, however, was a completely different experience.
5 I was encouraged to go on Disability. I was told that
6 there was no reason for me to work, since I could get
7 government assistance. I didn't feel as if the nurses and
8 the technicians were on my team. They were not supportive
9 when I was making my choices for therapy. They were
10 constantly pushing me towards hemodialysis; yet, none of
11 the nurses or technicians offered any reasons for their
12 opinions, other than they went as far to send other
13 physicians to talk to me and tell me how horrible
14 peritoneal dialysis was. I was told it takes up too much
15 space, it's messy, it's too hard. They even moved patients
16 around so I would end up sitting next to someone for four
17 hours or more who would try to talk me out of considering
18 PD. It's important to mention that this patient had never
19 even tried peritoneal dialysis. He was simply repeating
20 what they had told him.

21 I wasn't treated with respect or care. They
22 created an environment of negativity and stress that was
23 not conducive to dialysis therapy. I was very unhappy,
24 and, like anyone else in that situation, I looked for a

1 different place to receive my treatment. Sadly, there
2 wasn't a single alternative. Even now when I look back, I
3 get frustrated and disappointed that I didn't have a choice
4 as to where I sought dialysis.

5 Because I'm young and active, I have the
6 benefit of dialyzing at home. But I think that many other
7 patients who are elderly or ill, they do not have a single
8 alternative when it comes to where they dialyze. There is
9 a growing need for the kind of alternative that U.S. Renal
10 Care as proposed. Patients deserve, at the very least, a
11 choice of where they seek their treatment. I'm here today
12 because I was lucky; I had choices. The others do not have
13 choices, and that's a travesty.

14 The last point I would like to make is the
15 final thing a Fresenius nurse said to me. We were speaking
16 on the phone and I had just told her I was starting PD the
17 following day. She said -- and I quote -- "Don't worry;
18 when it doesn't work, you'll be back." This really sums up
19 my experience with Fresenius.

20 I urge the Board to approve U.S. Renal Care's
21 application to open a dialysis center in Oak Brook. My
22 experience with these doctors has been nothing but
23 positive, and I am thrilled that I would be able to
24 continue my care with them at this new facility.

1 Thank you for the opportunity to speak.

2 CHAIRMAN GALASSIE: Thank you.

3 Introduce yourself and spell your name for the
4 Recorder.

5 MS. MURPHY: My name is Kara Murphy (spells
6 name) I am Executive Director of the Access DuPage
7 program. We're a non-profit organization, operating in the
8 western suburbs, providing needed access to health services
9 for low income, uninsured residents of the community. I am
10 pleased to be able to speak today on behalf of offering
11 full support U.S. Renal Care's proposed dialysis center in
12 Oak Brook and also Bolingbrook, both of which are part of
13 or adjacent to the communities I serve.

14 Just a note about the organization that I
15 represent, we're not an insurance program; rather, we are
16 an effort to coordinate the volunteer based services of our
17 local healthcare community. For the last 10 years, Access
18 DuPage and its participating physicians have provided
19 eligible patients a fairly-comprehensive list of primary
20 and specialty health services, including nephrology. As I
21 write this letter, we have just over 10,000 enrollees.

22 Two of our participating physicians are
23 Doctors Rauf and Ahmed, and I have worked with them
24 consistently for the last number of years. If there is one

1 thing that I know about these physicians, it is that they
2 have been steadfast in their commitment to providing
3 charity services to the communities' most vulnerable and
4 uninsured residents. Based on the feedback I receive from
5 the men and women enrolled in Access DuPage and that they
6 have themselves treated, I can confidently assert that they
7 offer every patient the same high-quality care, dignity and
8 respect, regardless of ability to pay for the care that
9 they receive. Not only are they great partners in offering
10 pro bono services to our patients, but when they agree to
11 see a patient with impaired kidney function, it's important
12 to acknowledge that they are committing to multiple
13 time-intensive visits, often engaging in a care
14 relationship that lasts many months or even years, and yet
15 these physicians continually volunteer to take on new
16 cases. In anticipation of speaking at this hearing, I
17 talked to a number of my colleagues who report to me and,
18 in fact, coordinate specialty care services for my
19 patients, and I'm really humbled to say that in addition to
20 reporting to me that in the last year the doctors have
21 taken more than 10 new cases, they can also assert that
22 they have never once declined a case that was requested of
23 them. And not only do they accept those cases graciously
24 and quickly, but they then provide excellent care to those

1 patients.

2 As a part of an organization that looks out
3 for the medically-underserved patients in our community, I
4 respectfully ask you to approve these applications. I have
5 no doubt that these physicians will continue their
6 tradition and their demonstrated track record of care for
7 those in need as they embark on this new endeavor, bringing
8 more access to more patients in my community.

9 Thank you.

10 CHAIRMAN GALASSIE: Thank you, and I just
11 have to compliment Access DuPage. Having spent 30 years in
12 Lake and 20 as Director, it's an excellent, excellent
13 program, community partnership, and it's a model.

14 MS. MURPHY: Thank you, Chairman Galassie.

15 MS. TULCUS: Hello. My name is Vickie Tulcus
16 (spells name). I'd like to thank the Board for allowing me
17 to speak.

18 I am a dialysis patient, and I'm also a
19 member -- I work for Illinois Secretary of State Jesse
20 White. I worked in the organ and tissue donation field for
21 about eight years, first for Gift of Hope, the organ
22 procurement organization, and then Secretary White brought
23 me on about four years ago. So, you can understand how
24 ironic it is that I got sick and then ended up needing

1 kidney dialysis and a transplant. I'm kind of a joke in
2 the office. They tell me, "Vickie, you should have taken
3 that job with the Illinois State Lottery instead."

4 (Laughter)

5 MS. TULCUS: When I got sick, I had many
6 choices of hospitals to go to, doctors to choose, who to
7 treat me. When I needed dialysis, I had no more options.
8 Actually, I was assigned a place to go; I was assigned the
9 days that I had to go and the times that I had to go. So,
10 that meant on Christmas Eve day, I was at dialysis; on New
11 Year's Eve day, I was at dialysis. I used up all of my
12 sick time and, fortunately, people donated time, but when
13 that was over, I would miss two days a week from work, and
14 that meant two days of lost pay from work, two days that I
15 couldn't support -- help support my 88-year-old father, who
16 is a World War II veteran. This really impacted my life,
17 because I had no choice in dialysis.

18 In dialysis, I had no choice with the
19 technicians. I was lucky if I had the same technician,
20 there was such a high turnover rate. It was one time in my
21 life I was glad people actually wore name tags. The
22 technicians were very rude. They didn't like their jobs.
23 Most of them were overpaid -- I'm sorry -- underpaid, over
24 worked, and they didn't -- they didn't care, they told me

1 constantly. So, as I was being hooked up to dialysis, in
2 my ear I had to constantly hear about how they were so
3 unhappy with their work, about how they wanted more money,
4 and all I could think about was why did they seat me next
5 to the man who can't control himself, who always messed
6 himself, and for three hours I had to smell that, and that
7 smell would follow me home. I was nervous all the time and
8 anxious, because I was waiting, waiting, waiting. I would
9 get to dialysis early and I would have to sit and wait.

10 Doctors Rauf and Ahmed, they saved my life so
11 many times I can't tell you. They've spoken to my family.
12 I'm not married, so they have to speak to cousins. They
13 speak to them, keep them all informed. I'm able to do
14 dialysis at home. I am working full-time, which makes
15 Secretary White very happy, and I am so happy. I look
16 better; I feel better. I'm not missing work, and I
17 actually have accrued enough time that I went to Boston
18 with my cousins.

19 Please, I ask the Board to support this. We
20 need more choices in dialysis treatment. I am a living
21 example of these doctors who have saved my life three times
22 so far, and I'm so thankful. I thank God in my prayers
23 every night for them, and I please ask you to fully support
24 them, like I do, my family, and all of my friends. Thank

1 you.

2 CHAIRMAN GALASSIE: Thank you, Ms. Tulcus.

3 Can we talk to you about parking tickets later on?

4 (Laughter)

5 CHAIRMAN GALASSIE: No other public comment
6 on Project 11-024. Representatives from Project 11-024,
7 come forward.

8 (Pause)

9 CHAIRMAN GALASSIE: Good morning. If you
10 will introduce yourselves, spell your name for the
11 Recorder, and be sworn in. Thank you.

12 MR. VINSON: My name is Sam Vinson (spelled
13 name).

14 MR. LINDENFELD: Dr. Stan Lindenfeld (spelled
15 name).

16 MR. PIRRI: Steve Pirri (spelled name).

17 MR. O'CONNOR: Philip O'Connor (spelled name).

18 MR. RAUF: My name is Dr. Anis Rauf (spelled
19 name).

20 CHAIRMAN GALASSIE: Thank you, gentlemen.

21 (Oath given)

22 CHAIRMAN GALASSIE: Staff report.

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

24 Before I begin with the Staff report, I place in front of

1 you an overview of the number of dialysis projects we have
2 on this board meeting. There is ten in total. Three are
3 going to be heard today and seven tomorrow. What I tried
4 to do was outline for you what planning area they were in
5 and the bed need, the calculated -- I'm sorry, station need
6 in that planning area. What our intent is, if the Board
7 approves the project, we will tell the Board how many
8 stations are then needed or in excess at the time that
9 project is heard. For example, in HSA 9, today there is an
10 excess of 55 stations. Should you approve one of the four
11 projects, we will increase that excess by the number of
12 stations approved, so you will know immediately how many
13 stations are in excess.

14 MR. BURDEN: Mr. Chairman?

15 CHAIRMAN GALASSIE: Yes sir, Doctor.

16 MR. BURDEN: May I, before we begin to
17 consider this application, speak briefly, I hope. You
18 recognize I have a tendency not to be brief, but I wanted
19 to bring something to the attention, particularly to our
20 new Board members, and also a little history.

21 We've listened very carefully to the
22 preliminary speakers regarding their personal contact with
23 dialysis as a mode of treatment, and, respectfully, we're
24 happy to hear that. What I would like to do is indulge

1 everybody for a few minutes.

2 Those who have been involved know I have been
3 on this board for five years. I am looking around at some
4 of the attorneys that represent the companies that present
5 their applications to us. We're now looking at the Board
6 presented something -- the State Agency presented
7 something, which I was unaware was going to be here, but by
8 my count, I counted 11 ESRD applications in today's and
9 tomorrow's agenda. The growth of this entity is
10 encompassing enough that I felt, and still feel, we need to
11 have an ongoing, open seminar regarding what renal dialysis
12 presents to our state as cost. We are in a position to
13 recognize only mal-distribution and excess cost, as far as
14 these entities are concerned.

15 But in view of the history of dialysis, I'm
16 going to quote and read from a publication in November of
17 2010 that I have referred to before. ProPublica is an
18 entity. It's a not-for-profit entity. They're really more
19 left-leaning. Politically I'm not, but I recognize this is
20 a very interesting article, and I always felt that those
21 who are new and unexposed to what the history of dialysis
22 meant to this country should know a little more about it.
23 As a practicing urologist in our community for 40 years,
24 retired now 11 years, I was peripheral to this entity and

1 recognized its vast growth. Spare me a few moments and
2 allow me to read, if I would, from this article, rather
3 than trying to quote from it. I'm sure I'll miss it.
4 Everybody hear me okay?

5 (Pause)

6 MR. BURDEN: "In 1972, after a month of
7 deliberation, Congress launched the nation's most ambitious
8 experiment in universal healthcare: a change to the Social
9 Security Act that granted comprehensive coverage under
10 Medicare to virtually anyone diagnosed with kidney failure,
11 regardless of age or income." That's an important
12 statement, because you'll hear comments to the contrary
13 here today. "It was a supremely hopeful moment. Although
14 the technology to keep kidney patients alive through
15 dialysis had arrived, it was still unattainable for all but
16 a few lucky few. At one hospital" -- this is
17 interesting -- "a death panel, or 'God committee' in the
18 parlance of the time, was deciding who got it and who
19 didn't. The new program would help about 11,000 Americans,
20 just for starters. For a modest initial price tag of \$135
21 million" -- I think these numbers are important to know --
22 "it would cover not only their dialysis and transplants,
23 but all their medical needs. Some consider it the closest
24 the United States has ever come to socialized medicine.

1 "Now, almost four decades later, a program
2 once envisioned as a model for a national healthcare system
3 has evolved into a hulking monster. Taxpayers spend more
4 than \$20 billion a year" -- this was in 2010 -- "to care
5 for those on dialysis, about \$77,000 per patient, more, by
6 some accounts, than any other nation. Yet the United
7 States continues to have one of the industrialized world's
8 highest mortality rates for dialysis care. Even taking
9 into account differences in patient characteristics,
10 studies suggest that if our system performed as well as
11 Italy's, France's, or Japan's, thousands fewer patients
12 would die each year." It's controversial. I recognize
13 those in the audience who might challenge that, but if I
14 might --

15 "In a country that regularly boasts about its
16 superior medical systems, such results might be cause for
17 outrage. But although dialysis is a lifeline for almost
18 400,000 Americans, few outside this insular world have
19 probed why a program with such compassionate aims produces
20 such troubling outcomes. Even during a fervid national
21 debate over healthcare, the state of dialysis garnered
22 little public attention."

23 I'm going to skip around.

24 "The government has withheld critical data

1 according to this article about the clinics' performance
2 from patients, the very people who need it most.
3 Meanwhile, the two corporate chains" -- and that issue is
4 being someone challenged or brought up by at least one of
5 the applicants today. "Two corporate chains that dominate
6 the dialysis-care system are consistently profitable,
7 together making almost \$2 billion in operating profits per
8 year."

9 Quote from Tom F. Parker III, a Dallas
10 nephrologist: "We're offering our patients a therapy we
11 wouldn't accept for ourselves." More and more leaders in
12 the field, he said, "are starting to say this isn't
13 sufficient."

14 "As the United States moves to expand access
15 to healthcare" -- by the way, we're going to listen to some
16 applications later today regarding hospital chains
17 attempting to merger, also responding to the changes in the
18 delivery of healthcare -- "dialysis offers potent lessons.
19 It's story expresses the fears of both ends of the
20 ideological spectrum about what can happen when the doors
21 to care are thrown wide open: Neither government controls
22 nor market forces have kept costs from ballooning or
23 ensured the highest-quality care. Almost every key
24 assumption about how the program would unfold has proved

1 wrong."

2 I'm about done. I recognize there are some
3 controversial statements in there, but I thought it was
4 appropriate, at least for those that are new to our Board,
5 to understand a little about the history of how this came
6 to be such a huge business, and a very profitable business
7 I might add.

8 "The measure establishing taxpayer funding for
9 the treatment of end-stage renal disease, signed into law
10 by President Richard Nixon, was expansive, and its
11 lopsided, bipartisan approval reflected the times. Many
12 lawmakers, even conservatives, thought the United States
13 would adopt the European-style national healthcare system.
14 The program that took effect in July '73 was expected to
15 care for 35 (sic) patients and cost about a billion in its
16 10th year. The estimates seem to be laughable. The number
17 of dialysis patients surpassed 35,000 in 1977 and has gone
18 up from there."

19 "It's been a perfect example of that line,
20 'Build it and they will come,' says Dr. Jay Wish, Director
21 of Dialysis Services for University Hospitals Case Medical
22 Center."

23 I don't propose that this should influence our
24 Board members and their evaluation of this application or

1 the subsequent ones all concerning ESRD's. I have said for
2 some time, since I'm on the Subcommittee for Long-Term
3 Care, we need to have a subcommittee for renal dialysis
4 evaluation. It's grown to the point that it's representing
5 a larger amount of our time than -- all of us are
6 volunteers. It could become a GDF-time job, just trying to
7 keep track of all of the applications we have to face.
8 Recognize, these people on the Board have all volunteered.
9 We had somebody talking about earlier representing a more
10 ideological, racial complement. We had trouble getting
11 three more volunteers, because of a recent application that
12 caused the County of Cook to come three times in front of
13 us before we could evaluate their application regarding a
14 hospital that they attempted to close and build a support
15 outpatient facility for. We have nine people now. I don't
16 know how long they're all going to be here, as we expand
17 the amount of duty that we have.

18 I felt this was appropriate to talk about, the
19 history of dialysis. We're going to represent that each
20 one of us take a look at each application, make our mind up
21 independently of what we think is in front of us regarding
22 the application's applicant, and yet those -- I feel those
23 of us who are non-medical must be aware that this has
24 become a huge business. Hospitals are now faced with

1 enormous problems meeting their budget, closures are
2 eminent, sale of hospitals are going on. We've had that in
3 front of us now for the past two years, and now we're
4 seeing mergers, and I think it's appropriate to look
5 carefully at costs, which is what we're charged to do.

6 Thank you, Mr. Chair. I apologize for taking
7 so much time.

8 CHAIRMAN GALASSIE: Thank you, Dr. Burden. We
9 appreciate your perspectives, and you have long commented
10 on that. We, as a Board, have committed ourselves to do a
11 half-day retreat on the subject of dialysis, both to
12 educate ourselves and to put some things into context. We
13 have not been able to achieve that yet, but we are
14 committed to doing it, at this point, we believe, right
15 after the holidays. So, we would anticipate trying to put
16 this together in early January. Again, coordinating ten
17 different schedules is always the challenge. We are
18 committed to doing that.

19 Mike, do you have any more comments for the
20 Board on this chart you gave us?

21 MR. CONSTANTINO: No. I just wanted to try to
22 present to the Board an overview of what we're looking at
23 here today.

24 CHAIRMAN GALASSIE: And this is telling us

1 what's coming in front of us today?

2 MR. CONSTANTINO: Right, and tomorrow.

3 CHAIRMAN GALASSIE: Before I move forward,
4 any questions from Board members for Dr. Burden or Mike?

5 (Pause)

6 CHAIRMAN GALASSIE: Hearing none, gentlemen,
7 who would like to make some comments, please?

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

9 My name is Sam Vinson. I'm an attorney with
10 Ungaretti & Harris, representing U.S. Renal and its
11 physician partner in three applications for dialysis
12 centers here today: Oak Brook, Bolingbrook, and
13 Streamwood. In a few minutes I'll introduce the doctors
14 and U.S. Renal, but I'd like to make the point that common
15 issues overlap all three of these applications, and I
16 believe it would save the Board's time if we addressed all
17 of those simply once, rather than three times.

18 CHAIRMAN GALASSIE: We appreciate that.

19 MR. VINSON: So, in that event, what I'd like
20 to do is to introduce the Chief Operating Officer of U.S.
21 Renal, its President, Steven Pirri. Steve is a 25-year
22 healthcare veteran, 11 years in the dialysis world, and a
23 member of the board of the company.

24 MR. PIRRI: Thank you, Sam. My name is Steve

1 Pirri, as Sam said, and I am the President and Chief
2 Operating Officer for U.S. Renal Care. In the past, I've
3 been in dialysis for 11 years with three major companies --
4 or two major companies, one being Gambro Healthcare, Baxter
5 Healthcare up here in Chicago, and now U.S. Renal Care for
6 the past five years. My key role and responsibilities are
7 to manage the day-to-day operations of the patient's care,
8 also physician relationships, and what we're doing in the
9 managed-care market to make it affordable.

10 Our corporate office is in Dallas, Texas. We
11 also have ten regional offices throughout the country. We
12 first opened in 2000, in Paragould, Arkansas with one
13 patient and four employees. Over the past 11 years, we've
14 grown to 125 clinics and outpatient centers and PD units,
15 servicing 6,200 patients in 11 states, and employing more
16 than 2,000 caregivers in our organization. We are also in
17 the process of opening 11 more units throughout the country
18 in 2012.

19 Our clinical outcomes, which is measured by
20 all the industry standards within dialysis, meet or exceed
21 those averages. Dr. Lindenfeld will talk more about that
22 when it's his turn. One important point is U.S. Renal Care
23 has a history of accepting all patients referred by our
24 nephrologists, regardless of care. So, I know the access

1 folks were up here earlier. We look at every patient when
2 they're referred. We do take those patients into our care.

3 Why did we choose the Chicagoland area? Well,
4 we were approached by five premiere physicians to help
5 provide care to their patients in this area, Oak Brook,
6 Streamwood, and Bolingbrook. We feel competition only
7 increases the quality of patient care when patients have a
8 choice. It raises the bar. Simply, if you have a choice
9 to go to a different provider, a different center, you're
10 going to make sure that that center provider have better
11 quality care, or you're not going to go there. When there
12 are multiple competitors, patients can choose the times
13 they want to dialyze, discharges from hospitals become more
14 timely, healthcare dollars are saved, money is not spent on
15 trying to find a home for that patient, and an empty chair.
16 These are some of the reasons -- and you'll hear more --
17 why we would like this opportunity to show the patients in
18 the dialysis community in Oak Brook, Streamwood, and
19 Bolingbrook that U.S. Renal Care would enhance their care
20 by having the opportunity to choose us as a provider.

21 I want to thank you guys for your comments,
22 listening, your work, and having us here today.

23 Dr. Burden, I appreciate your comments also.
24 I'm not going to respond to them, because we only have

1 three minutes, and I think we can get in a long discussion
2 all day on that one. But they're well taken. So, once
3 again, thank you for your time.

4 CHAIRMAN GALASSIE: Thank you.

5 MR. VINSON: Mr. Chairman, I don't want to cut
6 off anybody who --

7 CHAIRMAN GALASSIE: Member Sewell has a
8 question.

9 MR. SEWELL: Yes. Mr. Pirri, you know, we
10 have a situation here where within the context of our
11 rules, it appears that in Health Service Area 7, there is
12 some under utilization of existing facilities, and your
13 call for more competition or more choice on the part of
14 patients, I think it has an attendant cost for the system.
15 In other words, you add more capacity, so now you're going
16 to have some unused capacity that I think the collective
17 society is going to have to pay for. So, I think that's a
18 dilemma that's almost universal when we're talking about
19 the delivery of expensive services. So, I guess I want you
20 to address that, because our rules, you know, estimate
21 whether there is a need for more capacity, and there is not
22 in this Health Service Area.

23 MR. PIRRI: Okay. I'm going to answer it in
24 two parts. Sam and those folks are going to get into the

1 capacity issue, as far as where we see the capacity going
2 as far as the problems with dialysis.

3 As far as added costs to the system, I
4 disagree with that. Here's the reason why. It's a pretty
5 easy one to look at. If you're a patient and you have
6 end-stage renal disease, you need to be dialyzed, plain and
7 simple. So, it's not that we can manufacture more patients
8 to get them into our clinic so we can charge more and bill
9 the government more and so forth. If you have end-stage
10 renal disease, there's really three ways to handle it:
11 Either at home, in the clinic, or in the hospital. As far
12 as the capacity issue, once those patients come into our
13 center, all of that cost and structure is on us. It's not
14 to the community itself, because the reimbursement is set.
15 The Medicare and State Medicaid pay a flat fee. Here's the
16 amount they pay, no more, no less, regardless of if you
17 have five patients or 55 patients in that center.

18 We wouldn't be looking at putting a
19 substantial investment in this area if we didn't feel the
20 need was, on a growth aspect, based on diabetes and
21 hypertension, and just based on the minority population
22 where it's going, to put those centers in.

23 MR. SEWELL: Mr. Chairman, I wanted to ask the
24 Staff a question. It has to do with reimbursement for

1 these services.

2 In the reimbursement of these services, is
3 depreciation and interest expense included?

4 MR. CONSTANTINO: Yes, sir.

5 MR. SEWELL: Then I would disagree with what
6 you just said, because if you create more capacity, there's
7 going to be more payments with depreciation and interest
8 expense on unnecessary capacity, according to the low
9 utilization of the existing ESRD stations.

10 MR. PIRRI: But --

11 MR. SEWELL: And it's for the system. It's
12 not for you as a provider. It's for us. That's the point
13 I'm trying to make.

14 MR. PIRRI: I still disagree with that a
15 little bit. I appreciate your stance on that. I just
16 still think that the positives outweigh the negatives, as
17 far as utilization, patient choice, and being able to do it
18 in a cost-effective way.

19 MR. GREIMAN: Mr. Chairman.

20 CHAIRMAN GALASSIE: Yes, Judge, question?

21 MR. GREIMAN: Yes. First a comment. The word
22 is "competition," and I personally see nothing wrong with a
23 little competition out there.

24 But I want to ask you about your charitable

1 activities. How was it that you doubled your charity
2 contributions in 2010? How did that -- what were the
3 reasons for that? How did that come about?

4 MR. PIRRI: Is that for me, sir?

5 MR. GREIMAN: Yes, or anybody that might know.

6 MR. PIRRI: I don't have that information with
7 me. I don't know.

8 Sam?

9 MR. VINSON: Justice Greiman, was the question
10 how our charitable contributions doubled?

11 MR. GREIMAN: Yeah, how did they double?

12 MR. VINSON: Well, essentially what has
13 occurred with the physician practices -- let me explain
14 this. U.S. Renal is a company which engages in joint
15 ventures with physicians. Physicians are brought into
16 ownership of the facilities, and the physicians in this
17 particular case, Dr. Rauf, Dr. Lang, Dr. Ahmed, in each
18 case have had relationships with Access DuPage and other
19 charitable organizations and have actually provided charity
20 care for them, and there is an intention to continue that
21 through these applications and to provide access in that
22 sense.

23 MR. GREIMAN: Okay. It just occurred to me
24 also that -- I don't know how many new facilities U.S.

1 Renal established in the year 2010. Obviously, if you
2 doubled your numbers of stations, you might well have
3 doubled your amount of charitable contributions at the same
4 time. So, maybe that's the answer. I don't know.

5 MR. PIRRI: That is part of the answer. We
6 merged with a company called DCA.

7 MR. GREIMAN: That may be part of it, but the
8 amount is quite significant.

9 MR. PIRRI: Well, what happens, Judge Alan, is
10 that when you look at charitable contributions, there's
11 something called the AKF, American Kidney Fund. We fund
12 that for patients that are unfunded, to help give them
13 coverage. So that probably was most of the part of why
14 that is, as far as the contribution.

15 MR. GREIMAN: Okay. Because I notice that,
16 actually, the Medicaid payments also doubled in 2010. So
17 that may be the reason.

18 MR. PIRRI: That is because we expanded with
19 DCA and combined the two.

20 MS. OLSON: I have a point of clarification
21 and then a comment.

22 Mike, just to make sure I've done my homework
23 correctly, is it correct that in this HSA, that 70 percent
24 of the market share in dialysis is Fresenius? Is that

1 correct? I believe I read that in the report.

2 MR. CONSTANTINO: That was a statement that
3 the applicants made.

4 MS. OLSON: And then also, is it not correct
5 that of the facilities that are not at utilization in this
6 HSA, that most of them are within 2 percent of our 80
7 percent target?

8 MR. CONSTANTINO: That's correct.

9 MS. OLSON: I just want to make a comment. I
10 had the privilege last summer of being at the hearing for
11 this particular application, and I hope Dr. Rauf is going
12 to speak, because I think that what we as a Board -- my
13 opinion is we need to take into consideration here is that
14 this is a different model that we're talking about here.
15 These are physicians who are committed in caring for their
16 patients and want to give their patients a choice. They're
17 outstanding when it comes to charity care. We're almost at
18 our target. There is a need for 8 stations in this area.
19 I would just ask my Board members to consider those things.

20 CHAIRMAN GALASSIE: Thank you.

21 MR. VINSON: Mr. Chairman, if I might, I'd like
22 to introduce Dr. Stan Lindenfeld, who is the Chief Medical
23 Officer of U.S. Renal, to discuss the medical plan and the
24 history of the company.

1 CHAIRMAN GALASSIE: Dr. Lindenfeld, were you
2 sworn in?

3 MR. LINDENFELD: Yes, I was, yes. I want to
4 thank the Board for their patience in hearing our
5 application for three facilities in the Chicagoland area.

6 I'm a nephrologist by practice. I was trained
7 at the University of California, San Francisco, and went on
8 and continued to practice there in a very, very wonderful
9 academic and private practice environment. I've been in
10 the ESRD field for 37 years. I enjoy being a practicing
11 physician to my population. I am Medical Director of two
12 facilities in the San Francisco Bay area, and I have always
13 dedicated myself to the care of patients, regardless of
14 socioeconomic status. It is in that spirit that my career
15 continued to expand.

16 In 1985, when quality management was just
17 beginning its national start in the healthcare industry, I
18 took it upon myself to become an expert in quality
19 management systems and became a national consultant for
20 hospital systems in national quality development. I
21 developed a system for UCSF, which was then modeled at
22 other academic medical centers around the country. I did
23 that while I was also, 50 percent of the time, in both a
24 teaching and direct practice involving nephrologic

1 patients. As a result of that, I had the opportunity to be
2 asked to play a role as Executive Medical Director for San
3 Joaquin Healthcare Services. San Joaquin County is a
4 relatively poor county in eastern San Francisco and
5 northern California, and I was asked to play that role
6 primarily because there was a desire to be able to convince
7 at that time the Board of Supervisors of the county to
8 allow the building of a brand new hospital facility,
9 because the existing facility could not deliver adequate
10 care to both the Medi-Cal -- Medi-Cal is the Medicaid for
11 California -- and the medical and indigent population in
12 the county. I was asked to play a role to convince the
13 board of that.

14 We worked through hearings for a year and a
15 half, because of very, very severe fiscal constraints at
16 that time in northern California, and we ultimately were
17 able to convince them that, indeed, the patients of that
18 county needed that kind of facility, and we were successful
19 in winning the board over and building that facility for
20 that population. It became literally a landmark for the
21 state and has been written about for that reason, and I'm
22 very proud to have been a significant part of that effort.

23 My quality management expertise then led me to
24 be asked to be involved with a new company that was just

1 starting, called Total Renal Care, in southern California.
2 Total Renal Care had been a subsidiary of an attendant
3 healthcare system, and they were going to branch out and
4 eliminate their subsidiary, and it was bought by a private
5 equity group, and I was asked to come in and consult with
6 them, to help them build a quality management system. At
7 that time, as I said, I was already wearing three different
8 hats, but the opportunity to help a newly-growing dialysis
9 company deliver quality care to its patient population was
10 one that I needed to consider, and I actually took on the
11 role of consulting in '94.

12 By the end of '95, I was so enamored of the
13 company and what their goals were that I turned the rest of
14 my practice, after 24 years, in San Francisco to my
15 partners and became a full-time Chief Medical Officer for
16 Total Renal Care. Total Renal Care then went through
17 explosive growth over the next three years and ultimately
18 became DaVita, which is now the second largest dialysis
19 provider in the country. When it made that transition, my
20 enjoyment in my role began to decrease, and so in 2002, I
21 retired, feeling that I really was not making the kind of
22 contribution I wanted to in now a very, very large public,
23 for-profit company on the New York Stock Exchange. And so,
24 I devoted myself to more personal interests, continued to

1 do consulting in healthcare quality management for various
2 organizations, and I was approached by U.S. Renal care to
3 help them. At that time, they were very small as Steve
4 said, and I didn't feel that they needed someone in a
5 position of Chief Medical Officer, so I helped them develop
6 a quality health management system but basically retained
7 my role as semi-retired.

8 However, three and a half years ago, as they
9 grew, I was approached again by the CEO and board of the
10 company and asked if I would now come on board to help them
11 develop systems to assure that we were delivering the
12 highest quality care. I came on board three and a half
13 years ago, and I have served as the Chief Medical Officer
14 of U.S. Renal Care ever since. That's my background.

15 In terms of my goal as CMO of USRC, I'm
16 basically the only physician on the Executive Board. I'm
17 the Senior Vice-President of the company. My role is to
18 push against, sometimes, the actual requirements of the
19 fact that we are a for-profit company. But my role is to
20 make sure that the delivery of high-quality care is
21 consistent with our company's goals and performance, and in
22 order to do that, I have developed a major data warehouse
23 for USRC. We track all of our clinical outcomes on every
24 one of our patients. We file report cards to that effect,

1 and we have been able to achieve superior outcomes,
2 compared to national standards, along every significant
3 clinical parameter in which we track. We have also been
4 able to evaluate our physician partnerships along the same
5 line, and it is in that role that I got a chance to meet
6 Dr. Rauf and Dr. Ahmed.

7 Because we were considering moving to the
8 Chicagoland area, and after meeting them, certainly from my
9 perspective, since I work very closely with both a medical
10 advisory board and all of our medical directors to
11 formulate policies, formularies, and procedures that meet
12 the needs of our medical directors and their particular
13 populations, I was very, very pleased with the idea that we
14 were now going to ask for permission to build three
15 facilities in the Chicagoland area and have Dr. Rauf and
16 Dr. Ahmed as our partners. This is a different kind of
17 company than the company that I once was involved with. It
18 does physician partnerships, and it takes their interests
19 extremely at heart in terms of making sure that the care
20 that we deliver is of the highest clinical standards and is
21 dictated by the physicians who understand their patient
22 population the best. Again, I will not speak against the
23 quality of care that is delivered by any of the large
24 chains. I know them well. I know the leaders of those

1 organizations. But I will say that USRC offers a different
2 choice to these patients.

3 I would like to say that in reviewing some of
4 the letters from the opposition, a point was made that
5 patients don't care about what clinics they go to or who
6 owns the clinics. I found that somewhat interesting,
7 considering all of the efforts CMS has put into the last 5
8 to 10 years in developing a web-based, dialysis facility
9 compare website, specifically so that patients and
10 patients' families can go and seek out and find out what
11 clinics are in their area, how they are performing in terms
12 of quality outcomes, and also who the ownership is, because
13 there is a concern among certain patient groups in terms of
14 the ownership of those facilities. So, I found that
15 comment in one of the letters to be somewhat disingenuous.

16 CHAIRMAN GALASSIE: And that exists for
17 providers other than your own?

18 MR. LINDENFELD: The CMS website? Yeah. It's
19 a --

20 CHAIRMAN GALASSIE: Yeah, I'm sorry.

21 MR. LINDENFELD: -- public website.

22 CHAIRMAN GALASSIE: Yes, I understand.

23 MR. VINSON: I'd like to introduce Dr. Gordon
24 Lang. Dr. Lang is a physician partner in the proposed site

1 at Streamwood. He is a long-time physician, nephrologist
2 in Chicago and western suburbs. He created Neomedica,
3 subsequently sold it. He has some very interesting stories
4 to tell you briefly about that, and I should also make the
5 point that Dr. Lang was the first physician to introduce
6 Fresenius machines into the marketplace.

7 CHAIRMAN GALASSIE: Dr. Lang, have you been
8 sworn in?

9 MR. LANG: No, I haven't.

10 CHAIRMAN GALASSIE: If you could swear
11 Dr. Lang.

12 (Oath given.)

13 MR. LANG: I just wanted to introduce myself
14 and give you a little more of my background. I went to
15 Duke for undergraduate, went to the University of Buffalo
16 for medical school, and then one of our graduates a year
17 ahead of us told us that Chicago was a good place to come.
18 At that time, it was the University of Illinois
19 (unintelligible) Hospital. And I can't say that he was
20 ever wrong. I've enjoyed my stay here. After that, I
21 started my residency at the University of Illinois
22 Hospital, but was drafted into the Navy. I served two
23 years aboard the USS James Monroe, which is a nuclear
24 submarine carrying 16 missiles. So if somebody did

1 something, I might run for a while until I got hit by the
2 radioactive storm.

3 After that, I came back and finished my
4 residency at the University of Illinois and then decided to
5 go into nephrology. I took my fellowship at Presbyterian
6 St. Luke's at that time, and at that time, just to update
7 Dr. Burden a little bit, that was 1968. In 1967, the State
8 of Illinois had passed a law that funded -- depending on
9 income, et cetera, funded dialysis for a certain
10 population, and that population were those people who
11 needed dialysis. There were restrictions on it, that you
12 could not be younger than age 50, you had to have primary
13 kidney disease, you had to go on home dialysis, and you had
14 to be a transplant candidate. As Dr. Burden said in the
15 article he's reading, in 1973 Medicare changed the rules,
16 and at that time, everybody could be eligible for dialysis.
17 I remember when Illinois was running the program, I did
18 lie, I'll admit it, for a lady who was African American. I
19 met her at the Mile Square Health Center, where I worked
20 when I was a Fellow. She had four kids and could not get
21 on dialysis because of hypertension. So I said she had
22 lupus or something else. She did get on dialysis. She
23 lived 15 years, saw all of her kids graduate from high
24 school.

1 After that, I did not start Neomedica myself.

2 I want to correct that. That was my partner Dr. Franklin
3 Schwartz, who really was the brains behind it, and I guess
4 I was kind of the rainmaker. I went out in the hospitals
5 and met people, and we were, I guess I would say, very
6 successful. I hate to say, Frank died two years ago.

7 We were very successful. We put together a
8 fairly large practice and added dialysis units where they
9 were needed. At that time, this was a CON state. We
10 went -- I went to the south side, we went to the west side,
11 we went north, wherever we had to go we went. The practice
12 grew, and finally some of my partners wanted to sell
13 Neomedica. At that time, it was fairly large. I think we
14 had 17 units and 26 nephrologists.

15 And so, it was sold to Fresenius Medical Care,
16 whom I had known for some time. I knew the CEO, Dr. Ben
17 Lipps. Dr. Lipps is the one who took the hollow-fiber
18 dialyzer and made it something that could be manufactured
19 and produced. The initial design was something done in
20 1912, but, obviously, in 1912 we didn't have the equipment
21 that would make it function. I remember when starting in
22 dialysis, we had coils, and the coils would rupture and
23 blood would go everywhere. With the hollow-fiber, that
24 didn't happen. They were much more efficient.

1 So, I knew Dr. Lipps for that and for some
2 other things, and finally we were doing things in machines
3 together, and he said, "I found this machine in Germany.
4 Do you want to go over and look at it?" So, I went over and
5 looked at it, and the machines looked good compared to the
6 ones we were looking at, and so I said, "I'll bring the
7 first 20 machines in."

8 We did alter the relationship over the period
9 of years, and then when my partners wanted to sell, we sold
10 to Fresenius Medical Care. I would say, thinking back,
11 that was probably my biggest mistake -- one of my biggest
12 mistakes. Not that Fresenius is a bad company; it's a very
13 good company. But what I did is I never thought about the
14 employees. Everyplace I go and every clinic I go, they
15 say, "Dr. Lang, remember when you had Neomedica? Are you
16 going to start a new clinic? Are you going to do this?" I
17 don't have 30 years anymore, but I am maybe doing something
18 in the future.

19 So, finally, I met Dr. Rauf really at Alexian
20 Brothers Medical Center, where he was an intensivist, and
21 he started talking about nephrology. He said he was
22 training in nephrology and that's what he wanted to do.
23 So, we started looking around in what was needed, and part
24 of the thing that I recognized as needed -- the population

1 has changed. When I started, the average age was around
2 50. It's now somewhere in the 70's. And so -- also, the
3 groups have changed. In the city, we had a large African
4 American population, small Hispanic population, but now the
5 populations have shifted. There is a larger African
6 American population in the suburbs, there is definitely a
7 larger Hispanic population, and the other growth, at least
8 in the Streamwood area, is an Asian Indian population, who
9 also have increased incidents of diabetes, apparently, and
10 need dialysis.

11 The thing that I look at when I look at the
12 age population -- and I know that there is a 30-minute
13 drive time. The problem is, when you have an older patient
14 and maybe the wife is driving that person or the husband is
15 driving the wife to dialysis, it is cumbersome and
16 burdensome to take somebody who is that age, especially in
17 a snow storm, to drive 30 minutes to a dialysis unit. So
18 my feeling is that we should have dialysis units closer to
19 where the people live, so it's easier for them to get
20 there.

21 The other thing that I wanted to stress is
22 that as a Medical Director with U.S. Renal, I feel that I
23 can talk to the people and I can get things done. I think
24 I've had a little bit of experience. I've been 43 years

1 now in nephrology. There are things that I would like to
2 see at least tried and to do, and one of the things I'm
3 interested in doing is looking at geriatric population.
4 One of the things that we should look at to put these
5 people on dialysis, are there reasons that maybe they
6 shouldn't go on dialysis? You know, this is talking to the
7 patient. I put two patients on dialysis and said, "If you
8 don't like it or at some time decide you don't want it, you
9 let me know, and then we will try to make it as comfortable
10 as possible to take you off dialysis." And this has
11 happened to two patients recently. One was 93, the other
12 one was 86.

13 And so the point is, I think the physician has
14 a responsibility -- which many of us don't do -- to talk to
15 the family and to talk to the patient about what do they
16 want? What do they expect? And these are the things that
17 I found that Dr. Rauf and Dr. Ahmed had that I had. I give
18 my cell phone to the patients. If they want to call me and
19 there's a problem, they can call me. If they call me too
20 much, then I tell them, "Hey, you're abusing the
21 privilege." But for the most part, people don't call you
22 that much.

23 And the other thing I want to point out, which
24 hasn't been pointed out, when we talk about dialysis, we

1 have to talk about the physicians. When I sold to
2 Fresenius, Fresenius signed a Medical Director Agreement
3 with our 26 physicians, and it was a fairly lucrative
4 Medical Director Agreement. I can't remember what the pay
5 was, but it was substantial.

6 I was also partially involved in creating this
7 growth for Fresenius in the area, because the people from
8 Everest, which was the competing group from Neomedica,
9 after we sold to Fresenius said, "Gee, can you make an
10 introduction of us to Fresenius? We want to sell." So, I
11 did, and you can see that ultimately Fresenius controls a
12 large part of the market here. But that's private
13 enterprise. I'm not finding any fault with that
14 whatsoever.

15 The other thing is they also have -- I think
16 there's 60 or 50 physicians in that group. So, you've got
17 somewhere -- besides the dialysis -- with all the dialysis
18 units, you have all of the physicians tied in, and I can
19 tell you one of the discharge planners at the hospital
20 joked with me. She said, "You know, Dr. Lang, there's more
21 competition among the nephrologists for patients than there
22 are for cardiologists." I said, "I didn't know that." She
23 said, "You know, the cardiologist won't give the patient
24 back if they've seen the patient before. I've never seen a

1 nephrologist do that."

2 One other point is that some of the units that
3 are not filled are related to the fact that some of the
4 medical directors cover a wide range of hospitals and are
5 seldom in the unit. A personal thing that happened to me
6 personally is that a physician wanted to transfer his care
7 to me in one of the units. I said, "No, I won't do that
8 unless your nephrologist approved it." He came back to me
9 a week later and said he approved it. The next thing I
10 knew, my privileges were denied at this facility. I had to
11 hire a lawyer. It cost me \$5,000.00 to get my privileges
12 reinstated, and my patient was force removed.

13 So, the point is, we need a different
14 approach. I think part of my problem with Fresenius now is
15 it just got too big. They've been very successful. I want
16 to commend them and all of the people I knew in Fresenius
17 and I still know them. They did a good job. But I think
18 there also has to be a place for a smaller group, where the
19 physicians are involved and they can talk to the people who
20 run the company, and I think that in this situation,
21 myself, Dr. Rauf and Dr. Ahmed, we have loud enough voices
22 that we will be heard.

23 I want to thank the Board for listening to
24 my a little bit longer than three minutes, but I thought it

1 was important.

2 CHAIRMAN GALASSIE: Thank you, Dr. Lang.

3 Questions? Judge?

4 MR. GREIMAN: I want to tell you about the
5 problems of this Board and maybe you can solve these
6 problems. About half of what we do is the acquisition of a
7 medical facility by a larger company, and as time goes on,
8 eventually medical -- from what I can see, medical units in
9 our state at least, I imagine in the country at large, will
10 be owned by a few big companies. That's what happens.
11 Half of what we do is a change of ownership. So, my
12 question to Dr. Lindenfeld or Dr. Lang is, will medical
13 treatment be better served if you have national -- large,
14 national corporations owning them and running it and caring
15 about making a profit? Is that where we're going? Because
16 that is where we're going, there is no question.

17 MR. LANG: I can't answer that, Judge. I'm
18 not sure what's the best way to go. All I can say is that
19 if I look at what I'm paid now from what I was paid when
20 Medicare first came in, it's certainly different. I'm not
21 complaining about it. It's what has to happen, because
22 there's more people on Medicare, and the government and
23 we -- saying that we're the government, really, because
24 we're paying the taxes -- we're going to have to look at a

1 way to solve this, and the point is, is it better for a
2 large company? I don't know that answer. All I can say is
3 stock at Fresenius is like \$72. It's probably higher than
4 a lot of other ones, and DaVita is up there, too. So,
5 they're making money, and that's not a problem. Insurance
6 companies make money.

7 MR. GREIMAN: I wasn't worried about them.
8 I'm concerned about the patients.

9 MR. LANG: That's why I think if we have some
10 smaller companies that are more responsive, it's easier. I
11 mean, part of the joke in the nephrology community is that
12 DaVita buys somebody, Fresenius is going to buy somebody,
13 and they just turned around and made an effort.

14 MR. GREIMAN: Exactly.

15 MR. LANG: DaVita bought DSI, which is here in
16 the neighborhood, and Fresenius to buy Liberty. So, the
17 point is, I'm not -- my own personal feeling, I don't think
18 big necessarily is good. I don't think big banks are good.
19 I used to have a mortgage at Lemont. I could talk to the
20 people at Lemont. Now I talk to somebody in the
21 Philippines or India when I have a problem with the Bank of
22 America.

23 MR. GREIMAN: That's the fear I have about
24 what we do on this Board, and we do -- it's what we do, and

1 we find ourselves locked in with larger operations, which
2 eventually that's where we're going to end up in the United
3 States.

4 MR. LANG: I'm trying to fight that. I'm
5 saying let's keep them at a certain level, you know. If
6 U.S. Renal wants to go public, that's fine, but let's keep
7 it in perspective. You don't have to have 250,000
8 patients, you know, and the point is --

9 MR. GREIMAN: Okay. Dr. Lindenfeld, do you
10 agree with that?

11 MR. LINDENFELD: Yes. I think it's important
12 to recognize that what is necessarily currently viewed as
13 the most cost effective is not necessarily the most
14 clinically effective, and that's a concern, and I think one
15 of the things that U.S. Renal Care, at least by entering
16 into the community, offers a different way of viewing the
17 practice of care, and I think that is a positive force.
18 But how long that's going to be able to be maintained, I
19 will tell you, Judge, that my concerns are very much along
20 yours, that we are heading towards basically ESRD being
21 under the care of two major corporations.

22 MR. GREIMAN: Okay. Thank you.

23 Dr. Lang, next time you need a lawyer,
24 Mr. Vinson is a little cheaper.

1 (Laughter)

2 MR. VINSON: I wasn't sure if I should address
3 you as Justice or majority leader. I'm not sure which
4 title is actually higher.

5 MR. GREIMAN: Majority leader for you, Sam.

6 MR. VINSON: I'd like to break our order of
7 presentation, if I might, for just a second and show you,
8 Mr. Chairman --

9 CHAIRMAN GALASSIE: Are you intending more
10 presentation, because I'm getting ready to move this issue.

11 MR. VINSON: No, I'm -- I'd like to just show
12 you some numbers that relate to --

13 CHAIRMAN GALASSIE: I think you've given
14 adequate information for the Board to move on this issue,
15 but thank you.

16 And, Judge, there's an analogy discussion to
17 have in terms of the home health business to what we're
18 talking about here and what happened in the 80's with
19 Medicare. This isn't the place for it, but it's very
20 analogous of what took place.

21 Any other questions on the part of Board
22 members on this issue?

23 (Pause)

24 MR. URSO: Is it -- you are the same

1 applicants on the next three projects; is that correct?

2 MR. VINSON: Yes, sir.

3 MR. URSO: And your desire was to give one
4 presentation on all three projects?

5 MR. VINSON: Yes, sir.

6 MR. URSO: I just want to remind the Board
7 that we do not do comparative reviews. We don't do
8 batching. Each of these projects has to be looked at on
9 its own merits and an individual vote will be taken on each
10 one separate. So, I just wanted to remind Board members of
11 that.

12 CHAIRMAN GALASSIE: And if you gentlemen will
13 stay at the table for each of the three, we will appreciate
14 that.

15 MR. CONSTANTINO: Mr. Chairman?

16 CHAIRMAN GALASSIE: Michael.

17 MR. CONSTANTINO: I didn't get an opportunity
18 to introduce this project.

19 CHAIRMAN GALASSIE: I'm sorry.

20 MR. CONSTANTINO: Would you like me to do
21 that?

22 CHAIRMAN GALASSIE: Yes.

23 MR. CONSTANTINO: The applicants are proposing
24 the establishment of a 13-station ESRD facility in

1 approximately 6,500 gross square feet of leased space in
2 Downers Grove, Illinois. The anticipated cost of the
3 project is \$1.9 million. The anticipated project
4 completion date is August 1st, 2012. This project was
5 modified to add a co-applicant, and there was a public
6 hearing held. We did receive a number of support and
7 opposition comments regarding this project.

8 Thank you, Mr. Chairman -- one other thing.
9 The current station need in HSA 7 is now 5. That has been
10 currently updated from the information I gave you in your
11 material. So, instead of 8, it should be 5 stations, need
12 of 5 in HSA 7. And the second thing is the same applicant
13 has another facility within the same planning area. That's
14 project 11-026.

15 CHAIRMAN GALASSIE: Mike, I'm sorry. I was
16 actually going to ask you to go ahead and give your Staff
17 report on 11-025 and 11-026 subsequently.

18 (Discussion held off the record.)

19 CHAIRMAN GALASSIE: Mike, I'm going to stop.
20 I'm going to change gears. Let's stay on 11-024 for Staff
21 report.

22 Any other questions by Board members?

23 (Pause)

24 CHAIRMAN GALASSIE: I will entertain a motion

1 to approve project 11-204.

2 MS. OLSON: So moved.

3 MR. BURDEN: Second.

4 CHAIRMAN GALASSIE: Moved and seconded. Roll
5 call please, Bill.

6 MR. DART: Motion made by Ms. Olson, seconded
7 by Dr. Burden.

8 Dr. Burden?

9 MR. BURDEN: We have to separate these three
10 applications?

11 CHAIRMAN GALASSIE: Yes.

12 MR. BURDEN: I personally, of course, am
13 confident Dr. Lang has been up-front, describing his
14 opportunity to provide some competition to the huge,
15 megalopolis, Fresenius and DaVita, which comprise 70
16 percent in the Oak Brook area. So, I would vote
17 independently now -- are we -- can I vote for all three
18 applications?

19 CHAIRMAN GALASSIE: This is an independent
20 vote strictly on 11-024.

21 MR. BURDEN: I'm going to vote for 204 (sic),
22 Oak Brook Dialysis.

23 CHAIRMAN GALASSIE: That's a yes.

24 MR. DART: Mr. Eaker?

1 MR. EAKER: Not being able to do batch votes
2 is kind of like in Major League Baseball, when you want to
3 walk intentionally a batter, you have to throw four wild
4 pitches in case something exciting happens.

5 (Laughter)

6 MR. EAKER: And speaking of Major League
7 Baseball, go Cards.

8 I vote yes.

9 CHAIRMAN GALASSIE: We might get through this
10 roll in the next few minutes.

11 MR. DART: Justice Greiman?

12 MR. GREIMAN: Aye.

13 MR. DART: Mr. Hayes?

14 MR. HAYES: Yes.

15 MR. DART: Mr. Hilgenbrink?

16 MR. HILGENBRINK: Yes.

17 MR. DART: Ms. Olson?

18 MS. OLSON: Yes.

19 MR. DART: Mr. Sewell?

20 MR. SEWELL: I'm going to abstain on this.

21 Can I explain that, Mr. Chairman?

22 CHAIRMAN GALASSIE: Sure.

23 MR. SEWELL: I can't bring myself to ignore
24 the excess capacity in the area. On the other hand, I

1 think something is being offered to the community that
2 responds to some of the things we heard in testimony, and
3 until we, as a board, have either a retreat or a
4 subcommittee to look at the ESRD in terms of
5 population-based need and take more things into
6 consideration, I'm reluctant to vote against it. So, I'm
7 going to abstain.

8 MR. DART: Chairman Galassie?

9 CHAIRMAN GALASSIE: Thank you, Mr. Sewell.

10 Chairman votes yes.

11 MR. DART: That's 8 votes in the

12 affirmative -- I'm sorry, 7 votes.

13 (Applause)

14 CHAIRMAN GALASSIE: That applause was for the

15 Staff report.

16 MR. CONSTANTINO: Thank you very much.

17 (Laughter)

18 CHAIRMAN GALASSIE: Now we're going to Item

19 11-025. However, I need to stop for a moment. We have

20 eight public comments requested for this item, and we have

21 two public comments following on the next item, 11-026.

22 So, bear with me. I need to ask the Board, do you need a

23 10-minute stretch? Lunch is at 12:30. Or are we able to

24 forge ahead? We are at 11:45.

1 (Discussion held off the record.)

2 CHAIRMAN GALASSIE: We will come back in ten
3 minutes.

4 (Recess)

5 CHAIRMAN GALASSIE: Thank you for being
6 reasonably timely. I will be pulling this back together.

7 And we're moving to Item H-2, 11-025, USRC
8 Bolingbrook Dialysis. We have eight individuals who have
9 signed up for comment. All but one are in support. I
10 would just ask, if you would like to testify in support, so
11 be it. If you feel your comments have been absorbed by the
12 previous presenters, you're not required to present,
13 obviously, but we're happy to have you, if you so choose.
14 We'll call your name, and if you would like to come up and
15 present, please do so. Again we will ask for a
16 three-minute duration, if possible, on public comment.

17 MS. AVERY: Roger Claar, John Rangel, and
18 Ricardo Morales.

19 CHAIRMAN GALASSIE: Good morning.

20 MR. CLAAR: Good morning. I've been honored
21 to have been mayor of Bolingbrook for the past 25 years.
22 I'd like to welcome you, first of all, to Bolingbrook, and,
23 secondly, to the Bolingbrook Golf Club, which is owned by
24 the Village of Bolingbrook, and we still have tee times

1 this afternoon.

2 (Laughter)

3 MR. CLaar: Anyway, first of all, I'll be
4 brief, because I've been through many, many meetings like
5 this myself. Rick Mace, our hospital administrator of
6 Bolingbrook Hospital attests to the fact that the hospital
7 is experiencing a significant increase in patients
8 requiring dialysis services. At the same time, the
9 availability of these services at existing facilities
10 become limited, which causes delays in patient discharge
11 and increases the patient's length of stay. Many patients
12 are currently being sent out of town, requiring the burden
13 of gas expense, enormous amount of time, commuting three
14 times weekly to maintain their health.

15 Bolingbrook, according to the 2010 census, is
16 over 73,000 people. We saw a significant increase in our
17 African American and Hispanic population, which is almost
18 half of our population. This, of course, results in
19 disproportionate incidents of diabetes and high blood
20 pressure, which are leading causes of kidney failure. Lack
21 of access to dialysis care will continue to increase
22 without additional chairs available. We anticipate the
23 volume of patients requiring the service to increase and
24 wish to assure there are adequate resources to meet the

1 needs of the patients in the Bolingbrook community. As
2 such, as Mayor, I strongly support this project and ask the
3 Board to approve the Certificate of Need for the U.S. Renal
4 Care facility in Bolingbrook.

5 Thank you.

6 CHAIRMAN GALASSIE: Thank you, Mayor, and
7 thank you for hosting us today. We appreciate that very
8 much.

9 MR. MORALES: Good afternoon. My name is
10 Ricardo Morales (spells name), and I, too, have been
11 privileged to serve the Village of Bolingbrook as a Trustee
12 for the past 10 years. Like Mayor Claar, I see a need in
13 our town. As a community leader, it is my responsibility
14 to do what is best for our residents and our surrounding
15 communities. I see a need that needs to be addressed by
16 you, the Board, and we thank you for taking the time and
17 your concern in listening to us.

18 As Mayor Claar stated, we have a diverse
19 community, but for what I know about the illness that
20 affects the kidneys, it is not selective about race, color
21 or creed. Yes, there is specifically more of a need now,
22 as stated, for the minorities, but I think this is going to
23 serve all the people of our area, not just our town but the
24 surrounding areas. Again, our town specifically is over

1 73,000, over 45 percent being minorities. But, again, the
2 other part of the population deserve just as much care as
3 well. As a Mexican American myself, I do have slight
4 concern more than others, I guess, but again, as a
5 community leader, I'm more concerned with the residential
6 needs, and I ask that you approve this petition today.

7 Thank you.

8 CHAIRMAN GALASSIE: Thank you, Trustee
9 Morales.

10 Good morning.

11 MR. RANGEL: Good morning, Mr. Chairman,
12 members of the Board. Thank you once again for having me
13 here. My name is Juan Rangel again, CEO of UNO.

14 (Applause)

15 MR. GALASSIE: Looks like you're buying
16 lunch, Juan.

17 (Laughter)

18 MR. RANGEL: Just to kind of place some
19 context to my earlier comments this morning regarding
20 Hispanic representation on the Board, and in spite of the
21 opposition to the proposal before you for additional
22 dialysis facilities in the area before you, the Members of
23 the Health Facilities and Services Review Board have the
24 unique opportunity today to ensure critical healthcare to

1 this region's growing Hispanic community. I want to thank
2 this Board for your support of the Oak Brook dialysis
3 station, and I'm here also to speak on behalf of not only
4 the Oak Brook facility but that of Bolingbrook and
5 Streamwood.

6 I certainly urge this Board to approve the
7 facilities that will be greatly helping the Latino
8 community and, as you may know, with greater choice and
9 competition, costs will be lowered for all, not just for
10 the Hispanic community. The strength of this region will
11 be determined about how well our government can adapt to
12 meet the changing needs of this community. It will also be
13 determined by the support that our leaders have for it
14 today. The recent endorsement by Mayor Claar, as you
15 heard, and Trustee Morales, as well as Representative --
16 State Representative Linda Chapa LaVia are evidence that
17 our leaders see the need to adapt with the ever-changing
18 healthcare needs in this area. I urge this Board to also
19 lead the way and approve all three proposals for additional
20 dialysis facilities.

21 Thank you.

22 (Applause)

23 CHAIRMAN GALASSIE: Thank you very much.

24 MS. AVERY: Next we have David Dreyfus, Pastor

1 Calvin Quarles, and Avtar Dhindsa.

2 CHAIRMAN GALASSIE: Good morning.

3 MR. DREYFUS: Good morning. My name is Dave
4 Dreyfus (spells name), no relation to the actor nor the
5 mutual fund.

6 (Laughter)

7 MR. DREYFUS: I am a transplant education
8 coordinator and outreach coordinator for the University of
9 Illinois Medical Center, Division of Transplant. I've been
10 involved in transplantation for 15 years, with the last 6
11 years being involved with outreach and education. I come
12 before you today because I support U.S. Renal Care's
13 application to establish dialysis centers in Bolingbrook,
14 Oak Brook, and Streamwood.

15 My responsibilities as an outreach coordinator
16 and educator is to go to the dialysis units to talk to
17 patients on dialysis. My heart goes out to the people with
18 end-stage renal disease, because they basically have three
19 choices: They either go on dialysis and stay on dialysis;
20 go on dialysis and hopefully get a transplant; or do
21 nothing and die a very quick and painful death. The
22 difference that I see in a lot of the dialysis areas --
23 it's really fulfilling -- is getting these people listed
24 for transplant, and it's very important about education. I

1 think transplantation needs education, education,
2 education.

3 I know Dr. Rauf and Dr. Ahmed. We've gotten a
4 few patients from their facilities listed on our Transplant
5 Center. Their patients are well-educated about transplant.
6 They're given many options of what they can do. Dr. Rauf
7 and Dr. Ahmed also are there for them. They're very
8 knowledgeable of their patients, and they stay in close
9 contact with the Transplant Center. Even after patients
10 transplant, they want to be involved in the patient's
11 follow-up care, which a lot of the Transplant Centers --
12 I'm sorry -- dialysis centers say, "Once a patient is
13 transplanted, they're your ball of wax," and they basically
14 are done with them. But not Dr. Ahmed or Dr. Rauf. They
15 truly want to follow up and be part of the transplant team
16 within individual transplant centers.

17 Transplantation itself people wait anywhere
18 from 5 to 7 years. So, another thing, too, is living
19 donation is down. You know, living donation -- out of all
20 of the people that Dr. Burden mentioned that are on
21 dialysis for end-stage renal disease there's only probably
22 20 percent that are eligible or have a donor or a family
23 member or friend that are either willing as well as able to
24 donate.

1 So, a lot of people are on dialysis. Diabetes
2 and hypertension is growing at an epidemic rate.
3 Dr. Crawford, one of the esteemed nephrologists in Chicago,
4 did a talk not too long ago and said they are two most
5 silent killers before us now. With that increasing amount
6 of people with hypertension, diabetes, there's also more
7 need for dialysis and transplantation.

8 CHAIRMAN GALASSIE: Thirty seconds, please.

9 MR. DREYFUS: I ask you to approve the U.S.
10 Renal Care's applications to bring needed dialysis
11 facilities to this region, provided by these doctors, who
12 make the right decisions for these patients.

13 Thank you.

14 CHAIRMAN GALASSIE: Thank you very much.

15 MR. BURDEN: Mr. Chair, can I ask one question
16 of this gentleman?

17 CHAIRMAN GALASSIE: Certainly.

18 MR. BURDEN: I'm glad you were here to present
19 what you did. My question is clearly, what one-word or
20 two-word answer -- do you get the same feeling with the
21 competing dialysis, mega, large companies I won't mention
22 by name -- you know who I am talking about -- that
23 follow-up and care for patients who present and get the
24 adequate information necessary to be a candidate for a

1 transplant? That's one of my big things I'd like to see,
2 more transplants done. I'm asking. You can answer as you
3 see fit. I'd like to know what you just said regarding
4 this applicant's interest in seeing patients evaluated more
5 completely and being referred for transplant, does this
6 exist, to your mind, with the competitor institutions?

7 MR. DREYFUS: In the six years that I've been
8 an outreach person and involved in terms of getting people
9 to the transplant centers, we're seeing a lot more of
10 doctors basically referring them and being out of the loop
11 until they get the transplant done. Dr. Rauf, Dr. Ahmed,
12 and the few patients that we have vested, they are in on
13 all times of how -- what tests are being done. They want
14 the results as well, not that it would pertain to them,
15 because they're in for a transplant. So, there should
16 be -- I agree with you, I think more nephrologists should
17 be more involved in the actual work-up. But, then again,
18 you have so many patients that are on dialysis, it is
19 really, really hard to comprehend and take in how many
20 patients a nephrologist has to follow.

21 CHAIRMAN GALASSIE: I take that as a yes.

22 MR. DREYFUS: Yes. Thank you.

23 CHAIRMAN GALASSIE: Thank you.

24 If you would introduce yourself, sir, spell

1 your name, please.

2 MR. QUARLES: My name is Calvin Quarles, and
3 I'm the pastor of the Bolingbrook Community Church.
4 (Spells name.)

5 I want to take this opportunity to thank the
6 Planning Board for this moment to come in and share. First
7 of all, as a pastor we are typically accused of being
8 long-winded. You guys got me beat by a long shot. We
9 don't get to take lunch breaks in the middle of our
10 sermons. So I'll go on with this.

11 (Laughter)

12 MR. QUARLES: I am, as I said, the Senior
13 Pastor of the Bolingbrook Community Church, which I
14 consider to be a real labor of love and a real blessing to
15 me. I've been doing that for the past 9 years, have really
16 had a great opportunity here in the Bolingbrook community.
17 Lived in Bolingbrook for the past 16 years. As a Christian
18 minister, I've had the opportunity to serve as the leader
19 of the Bolingbrook Clergy Association and have been
20 involved pretty much throughout the community, doing
21 whatever projects need to be done for the benefit of our
22 schools, for the benefit of our children primarily, and
23 just really have a real heart for our community.

24 One of the things that I know is that there's

1 some increasing issues and problems in Bolingbrook
2 particularly in the health arena, which is why I was
3 certainly honored and pleased to see that the Bolingbrook
4 Hospital did come to this community. We knew that that was
5 something that we wanted to see take place, and I was glad
6 when it did. So, I certainly was encouraged when I heard
7 there was another opportunity for a medical facility to
8 come to Bolingbrook.

9 As you know and you've heard it said, our
10 village is growing. Over the past decade, it has certainly
11 increased significantly. Having been here for the past 16
12 years, I've seen the number of minorities to come into this
13 community to increase significantly. I think I've heard
14 numbers in the area of 44, 45 percent, what have you. I
15 know that's a significant number. I know that this issue
16 of dealing with high blood pressure or hypertension is
17 something that is personal to me, being one who takes high
18 blood pressure or hypertension medication on a daily basis.
19 I know the significance of it. I know the impact it has on
20 my family and on my community. So, I'm certainly here not
21 only because I want to support this effort, but also
22 because I have a personal interest and want to see things
23 changed, want to see things done at what I would consider a
24 much better way than I've heard described in the past.

1 I don't know a whole lot about the industry.
2 I've never sat through a meeting of this nature before.
3 I'm not so sure I want to go through this again. But I
4 will say this: I do believe that there is a need in this
5 community for a facility of this nature, increased ability
6 for those who are dealing with these particular issues.
7 So, I want to once again encourage you to consider
8 approving the request that has been made by U.S. Renal, and
9 I'm going to ask that you would do that, and I thank you
10 very much for this time.

11 CHAIRMAN GALASSIE: Thank you, Pastor
12 Quarles, and you're welcome to come back tomorrow, if you'd
13 like to.

14 MR. QUARLES: Not unless I can bring my
15 congregation and get applause like the others did.

16 (Laughter)

17 MS. AVERY: I'm assuming that Dr. Dhindsa is
18 no longer with us.

19 AUDIENCE MEMBER: He had to go to a surgery.

20 MS. AVERY: Next we have Cartrell Collins,
21 Pedro Anaya, and Brian Brandenburg.

22 (Pause)

23 CHAIRMAN GALASSIE: Good morning, sir.

24 MR. COLLINS: Good morning.

1 CHAIRMAN GALASSIE: Just introduce yourself,
2 and spell your name for the Recorder.

3 MR. COLLINS: My name is Cartrell Collins.
4 I'm presently a patient of Dr. Rauf and Ahmed, and
5 chankfully, I have just received a kidney transplant, so
6 I'm one of their success stories.

7 CHAIRMAN GALASSIE: Congratulations.

8 MR. COLLINS: Thank you. And I just really
9 would like to let the Board know that these doctors really
10 helped me, really, in terms of knowledge and information,
11 from the start of this whole process to where I am now
12 today, and I think it would be an injustice if the
13 application had any kind of problems, because there is a
14 need, there's a great need, and these doctors can
15 facilitate that need. So, I won't go into any other
16 details. I think it's been spoken of throughout this whole
17 Board forum. But, again, just really would like to let
18 this Board know that these are some good doctors, who have
19 their personal interest in their patients, and they really
20 showed it to me, and if I had to go to ten of these to make
21 the point clear that these doctors are well worth their
22 salt for any community, that would be it.

23 Thank you.

24 CHAIRMAN GALASSIE: Thank you, Mr. Collins.

1 MR. BRANDENBURG: Good afternoon. I will just
2 reintroduce myself. Brian Brandenburg from Fresenius
3 Medical Care, Regional Vice-President.

4 Just a couple of comments, the first being
5 about -- in response to some of the comments about quality.
6 I do take exception to the fact that it's been stated that
7 Fresenius and other large dialysis providers provide
8 substandard care, and I would say that from personal
9 experience, I do know that we do provide exceptional care
10 and we are very focused on things like catheter reduction
11 and home therapies, transplantation, and working with the
12 patients to improve the quality of their care.

13 Secondly, I'd like to make the comment that I
14 would ask the Board apply its rules consistently. We've
15 been presenting in front of the Board for many years, and
16 one of the things that we do appreciate is the consistent
17 nature in which you do apply and grant projects.

18 Next thing I'd like to speak about is
19 regarding the physical site that's been chosen by U.S.
20 Renal for the Bolingbrook facility. It is just across from
21 our Bolingbrook facility and it would seem, to provide
22 optimal access to the residents in Bolingbrook, a different
23 location would have been chosen to create an equal
24 distribution in stations.

1 We also question the referral information
2 provided by the physicians. Over the past three and a half
3 years, approximately 79 patients were referred by the
4 physicians supporting the proposed Bolingbrook facility, to
5 a total of twelve Fresenius facilities spanning
6 Chicagoland. This does not correlate to the number of
7 patients they claim will be referred to the three proposed
8 U.S. Renal facilities. For example, as of the second
9 quarter, they only had 10 patients at our Bolingbrook
10 facility, and yet state they would refer one in six
11 patients in the next two years to the proposed facility.

12 We are also concerned that in an attempt to
13 gain favor with this Board, a new provider to Illinois
14 would also make inaccurate and misleading statements about
15 other providers of dialysis, as opposed to addressing the
16 Board's criteria. U.S. Renal and its physicians cite three
17 patient care accounts, claiming that Fresenius restricts
18 admissions to patients with a central venous catheter for
19 dialysis access. All three examples were refuted by
20 Fresenius and by the physicians involved in these patients'
21 care. In fact, over the last two years, 20 patients, all
22 with central venous catheters, have been admitted to the
23 Bolingbrook facilities by Doctors Rauf and Ahmed.

24 We also note that Doctors Rauf and Ahmed have

1 never once attended a quality, monthly meeting at any of
2 the Fresenius clinics they admit to. If they had issues
3 about Fresenius admissions or quality, it would seem
4 logical that they would have attended at least one of those
5 meetings to voice their concerns. In reality, they are
6 making these allegations opportunistic now to gain approval
7 for their clinics.

8 In sum, we encourage the Board to look at the
9 referral information carefully, consider the location for
10 the proposed site, and finally, we ask the Board to
11 discourage the type of disparaging remarks made in its
12 application and ask that the applicants focus on the
13 Board's review criteria.

14 CHAIRMAN GALASSIE: Thank you,
15 Mr. Brandenburg.

16 Any other public comments on item 11-025?

17 (Pause)

18 CHAIRMAN GALASSIE: Hearing none, the
19 representatives are here in the room, though not at the
20 table. Are there any questions from the Board for them?

21 (Pause)

22 CHAIRMAN GALASSIE: Mike, would you give your
23 presentation, please?

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

1 MR. DART: The motion was made by Dr. Burden,
2 seconded by Justice Greiman. Dr. Burden?

3 MR. BURDEN: I am moved by the fact that the
4 applicants appear to be generating, indeed, an element of,
5 shall we say, competition, but I have to look also at the
6 fact that we are 55 beds in excess currently in HSA 9.
7 There also is a 30 percent, shall we say -- 30 percent of
8 the facilities are operating below target occupancy. I
9 would have to say that I would vote against this applicant
10 at this particular time because of that, because I what I
11 mentioned.

12 MR. DART: Mr. Eaker?

13 MR. EAKER: I vote yes.

14 MR. DART: Justice Greiman?

15 MR. GREIMAN: Aye.

16 MR. DART: Mr. Hayes?

17 MR. HAYES: Yes.

18 MR. DART: Mr. Hilgenbrink?

19 MR. HILGENBRINK: Yes.

20 MR. DART: Ms. Olson?

21 MS. OLSON: Yes.

22 MR. DART: Mr. Sewell?

23 MR. SEWELL: No, for the same reasons as --

24 much more excess capacity in HSA 9.

1 MR. DART: Chairman Galassie?

2 CHAIRMAN GALASSIE: Yes.

3 MR. DART: That's six votes in the
4 affirmative, two negative.

5 CHAIRMAN GALASSIE: Motion passes.

6 Moving on then to Item 11-026, USRC Streamwood
7 Dialysis. We have two public comments, if these
8 individuals are still here.

9 MS. AVERY: Clare Ranalli and Brian
10 Brandenburg.

11 MR. BRANDENBURG: Hello, again. Regarding the
12 U.S. Renal Streamwood project, I just want to make clear
13 that we're not opposing the application on the basis of
14 need, as Fresenius has always promoted access to dialysis
15 services. In addition, we believe the Board is best
16 situated to determine where access is available based on
17 unique circumstances of each application.

18 We are concerned that in an attempt to gain
19 favor with the Board, the provider stated inaccurate and
20 misleading statements about other providers in dialysis, as
21 opposed to addressing the Board's criteria. U.S. Renal
22 questions Fresenius surveys show extremely high rates of
23 patient satisfaction overall in our clinics. U.S. Renal
24 claims that Fresenius' admission policies negatively impact

1 patients and raise healthcare costs. Fresenius same
2 standards that all other dialysis providers are subject to
3 and which U.S. Renal is. Also, many of those admission
4 requirements are mandated by CMS, such as the requirement
5 of a recent hepatitis screen. Patients' insurance must
6 also be verified. Fresenius Care makes every attempt to
7 admit a patient within 24 hours. However, if we do not
8 have the required information for CMS, there may be a
9 delay, as we cannot violate those regulations.

10 In sum, while not provided as comment on this
11 particular application, prior comments on the U.S. Renal
12 Bolingbrook and Oak Brook projects do apply and should be
13 considered as well.

14 CHAIRMAN GALASSIE: Thank you again.

15 Do the Board members have any questions
16 regarding this applicant and application?

17 (Pause)

18 CHAIRMAN GALASSIE: Michael, would you give
19 the presentation first?

20 MR. CONSTANTINO: Yes, sir. Thank you,
21 Mr. Chairman.

22 The applicants are proposing the establishment
23 of a 13-station ESRD facility, located in approximately
24 5,800 gross square feet of leased space in Streamwood,

1 Illinois. The anticipated cost of the project is
2 approximately \$1.7 million. This project was modified also
3 on July 28th, when the applicants added a co-applicant. A
4 public hearing was held on this project, and we have
5 received both support and opposition letters regarding this
6 project. This is a second application by this applicant
7 within the HSA 7 Planning Area. Project 11-024 was
8 approved by the Board, and now this planning area shows an
9 excess of 5 stations. We also note there is no lack of
10 service within 30 minutes of the proposed facilities, as
11 there are existing facilities operating below target
12 occupancy. Average utilization within 30 minutes is 67
13 percent. 9 of the 13 facilities within 30 minutes are
14 operating below target occupancy.

15 Thank you, Mr. Chairman.

16 CHAIRMAN GALASSIE: Thank you. Appreciate
17 that.

18 Any questions by Board members?

19 MR. HAYES: Mr. Chairman, I'd like to ask them
20 specifically if someone could describe, why is there a need
21 or why is this facility needed in Streamwood?

22 CHAIRMAN GALASSIE: Whoever is responding, if
23 you would please come up to the mic. Thank you.

24 MR. URSO: You've already been sworn in.

1 MR. VINSON: Mr. Chairman, Sam Vinson on
2 behalf of U.S. Renal, and I'm going to make a very brief
3 comment on that and then turn the presentation over to Dr.
4 Lang, who knows the area extremely well.

5 I would make the point that in this particular
6 planning area, there's been an enormous change in
7 population between the 2000 and 2010 census. What that
8 population change demonstrates is that there has been a
9 substantial increase in persons of Hispanic, African
10 American, and aged background. Each of those groups has an
11 enormously higher incident rate of end-stage renal disease
12 than the general population. As a matter of fact, when you
13 look at the numbers, the average rate is somewhere around 3
14 to 1. So, as a consequence, this substantial change in
15 population mix has created a situation where there is far
16 more demand, far more need than you might expect from a
17 comparable population.

18 Now, one of the things that your criteria
19 takes into account is the general increase in the whole
20 population and the prevalence of the disease. It doesn't
21 take into account the subgroups within the population that
22 have particularly high incidences, African Americans,
23 Hispanic; also in this situation, Asians of Indian
24 background and, finally, the Asian. So as a consequence,

1 what your formula fails to do in predicting need is to deal
2 with the high incidence of those subgroups that has
3 dramatically grown in the planning area.

4 I could go on at some length, but that is
5 generally the point, sir, that I would make. Now, Dr.
6 Lang, I think can deal with it much more directly.

7 MR. LANG: I think the reason I picked
8 Streamwood is if I looked around where the dialysis units
9 were and where this older population that's aging has to
10 drive, there are a large number of patients who are from
11 Streamwood, and these are specifically patients that are
12 admitted both to St. Alexius Medical Center and Alexian
13 Brothers, but more so St. Alexius. And for that reason --
14 it's much easier for them in bad weather and in the winter
15 to get to a unit that's closer to their home, and that
16 reason is one of the reasons I picked Streamwood, and U.S.
17 Renal agreed.

18 I think it's important to recognize that
19 people who get dialysis usually need help after dialysis,
20 unless they're very young. They feel kind of worn out,
21 because you've done in nearly 3 to 4 hours what normally
22 your kidney would do in 24 hours. So, if we're taking off
23 3 liters of fluid, because they've gained that much, they
24 don't feel perky. They're not going to go out and play a

1 round of golf on this beautiful course here. So, I think
2 that's the reason Streamwood was picked.

3 And the other thing I wanted to point out, on
4 those facilities that are not functioning at 80 percent --
5 I mentioned this before -- one doctor who admits to one of
6 the units -- and I'm not going to name the unit -- he lost
7 two partners. So, obviously, the patients who he was
8 seeing or who his partners were seeing go to other doctors
9 who are admitting to another unit. Another doctor that I
10 know, basically where I had my problems with, he is hardly
11 ever in the unit. He's moved his practice to I think up in
12 McHenry County and he goes to various hospitals and I think
13 has a chauffeur to drive him around. So, for that reason,
14 if you're not at the hospital, relating to the primary care
15 physicians, you don't get the referrals. So, because his
16 facility is not filled, it means he's not doing his job.
17 It's not the facility's fault. In fact, one of the
18 facilities has a sign up on 79, advertising for patients.
19 That's because the doctor is never around. So, I don't
20 think it's my fault that the facility is not full.

21 And the point is, I want to have it closer to
22 where the patients live. That's my reason. My brother was
23 on dialysis. He got a transplant. So I know what these
24 people go through. So thank you for hearing me again.

1 CHAIRMAN GALASSIE: Thank you.

2 MR. CARVALHO: Mr. Chairman?

3 CHAIRMAN GALASSIE: Yes, Mr. Carvalho.

4 MR. CARVALHO: Thank you, Mr. Chair.

5 Something about what I heard this morning
6 didn't quite make sense, so I checked with our person who
7 does the inventory. The thing that didn't make sense is
8 the demographic differences in this planning area today are
9 not something that is as historical in Africanism. In
10 other words, there are different demographics in the state,
11 and there have been forever. So, I never heard this
12 discussion before, that our analysis of need is incorrect
13 because it doesn't take into account the demographic
14 difference. So, I checked with the person who put the
15 inventory together and said, "Has this ever come up before
16 about the fact that the need adjustment ought to be
17 disregarded because it's not accurately reflected in the
18 demographics of an area?" And the thing is, the -- let me
19 make two different points.

20 The need determination might be a little
21 out-of-date because of the passage of time, but, in fact,
22 the use rate of the area is the use rate that's used to
23 calculate need, which is to say if you're in an area that
24 demographically has a population that has a high

1 utilization, then that utilization will be the utilization
2 used to calculate need. If the area is one that is at the
3 State average or lower, then the State average will be
4 used. So, for example, any existing population that has a
5 high user of end-stage renal dialysis, their high use will
6 affect the need calculation.

7 Having said that, if the demographics have
8 changed dramatically from the time that our inventory was
9 calculated, then our inventory could be out-of-date. So,
10 the first point is our need analysis does take into account
11 demographics. But the second point is there's a time lag
12 if you have a demographic change in area. So, for example,
13 the demographics of the south side of Chicago are pretty
14 steady, so those use rates have taken into account the
15 historically high African American population there. If
16 you have an area that is demographically changed from our
17 base of calculation, then the use rate would not take into
18 account any increase.

19 So, for purposes of your consideration, the
20 need calculations that you have in front of you are based
21 on 2008. So, the applicants can inform us of any
22 demographic changes from 2008, but it is not the case that
23 demographics are not taken into account in the need
24 calculation. They are.

1 MR. SEWELL: I guess I'm a simple person,
2 unlike counsel over there. I think another way to say this
3 is we don't have a need-base formula. We have a
4 demand-base formula.

5 MR. CARVALHO: A utilization-based.

6 MR. SEWELL: Same thing. So, if the
7 demographics were working in favor of higher utilization,
8 it would be reflected. The only difference from making
9 that point, of course, would be the time lag, you know, and
10 what -- is it 2008 when we did this?

11 CHAIRMAN GALASSIE: Yeah.

12 MR. SEWELL: That I don't know. I don't know
13 how much has changed since 2008.

14 CHAIRMAN GALASSIE: Yes, sir.

15 MR. VINSON: Mr. Chairman, Member Sewell, the
16 point that I would make is you're right to think about
17 2008. We're in 2011. If you were to approve this
18 application, it would take a year to build the facility,
19 and the utilization rate that you would apply would be the
20 utilization rate two years later. So, you would be dealing
21 with a six-year period of time, and if the population
22 trends continue to occur as they have in the past decade
23 between 2000 and 2010 census, that's where you're fishing
24 behind the net.

1 MR. LANG: Mr. Chairman could I add one more
2 point?

3 CHAIRMAN GALASSIE: Sure.

4 MR. LANG: The other thing I don't like to do
5 is send patients to a fourth shift, and I'll just mention,
6 Fresenius runs a fourth shift at Hoffman Estates, and I
7 think that's not good for the patients. And the other
8 thing that -- talking about need, with the clinic that I
9 started many years ago, Rolling Meadows, it's below 75
10 percent, and Fresenius opened a clinic recently in
11 Palatine, which I'm sure took some of the patients from
12 there. So, I think you can skew the statistics, the use,
13 by doing various things. So, that's why I still think we
14 need one in Streamwood.

15 CHAIRMAN GALASSIE: Thank you, Doctor.

16 I think we're ready for a vote on this issue.
17 May I have a motion to approve Project 11-026 to establish
18 a 13-station ESRD facility in Streamwood, Illinois.

19 MR. HILGENBRINK: So moved.

20 MR. BURDEN: Second.

21 CHAIRMAN GALASSIE: Moved and seconded. Roll
22 call, please.

23 MR. DART: Motion made by Mr. Hilgenbrink,
24 seconded by Dr. Burden.

1 Dr. Burden?

2 MR. BURDEN: We're faced with the aspect of
3 need. I've listened to the explanations presented by the
4 applicants, and I am going to vote for this application for
5 the reasons that I alluded to.

6 MR. DART: Mr. Eaker?

7 MR. EAKER: Yes.

8 MR. DART: Justice Greiman?

9 MR. GREIMAN: Aye.

10 MR. DART: Mr. Hayes?

11 MR. HAYES: Yes.

12 MR. DART: Mr. Hilgenbrink?

13 MR. HILGENBRINK: Yes.

14 MR. DART: Ms. Olson?

15 MS. OLSON: Yes.

16 MR. DART: Mr. Sewell?

17 MR. HILGENBRINK: I abstain for the same

18 reason I did on the other HSA 7 application.

19 MR. DART: Chairman Galassie?

20 CHAIRMAN GALASSIE: Yes.

21 MR. DART: That's 7 votes in the affirmative.

22 CHAIRMAN GALASSIE: Motion passes.

23 Congratulations. Good luck. Someone should share that
24 chart with the UNO organization that was here this morning,

1 because that's certainly the point we are trying to make.

2 DR. BURDEN: Thank you to the Board for
3 listening to my talk.

4 CHAIRMAN GALASSIE: Good luck.

5 The Board will -- you're going to need your
6 agenda in front of you for the next moment, because the
7 Chair is going to recommend several changes to move the
8 days along. Coming up is Items 11-039 through 11-053, all
9 Resurrection and Provena. We have talked with them, and
10 they have agreed to make one presentation, though we will
11 go -- introduce each item individually. If there are
12 questions by the Board on that item, they will address
13 them. If not, a vote will take place. So, these fifteen
14 will be treated individually but with one presentation.

15 That having been said, Item H-19, we are going
16 to move up to be first after lunch, which seems reasonable,
17 considering there's fifteen ahead of it. So, H-19 will be
18 directly after lunch.

19 Thirdly, for the Board members, depending upon
20 time, if it's relatively early, meaning 1:30 or 2:00 -- and
21 I'm guessing it will be -- I would recommend we take Items
22 10 through 13, address those this afternoon, probably
23 adjourning around 3:30. If we have time, we'll do
24 Executive Session today. If not, we'll do that tomorrow.

1 But the point is, we would move these items today, deal
2 with them this afternoon, then hopefully adjourning
3 tomorrow around noon. That seems to make more sense than
4 adjourning early today and putting in a full day tomorrow.
5 I see heads bobbing.

6 Last question -- honestly, and we can go eat.
7 Shall we cancel lunch tomorrow or maintain lunch, not
8 knowing how long it will go?

9 MR. EAKER: Maintain.

10 CHAIRMAN GALASSIE: We'll keep lunch. If
11 anyone thinks that they prefer not to stay for lunch
12 tomorrow, if you could let Cathy know or Courtney know.

13 Thank you very much. We're adjourned for
14 lunch. We will return about 1:30.

15 (Lunch recess.)

16 CHAIRMAN GALASSIE: Thank you for being
17 timely, ladies and gentlemen. Welcome back.

18 We are looking at Item 11-063, Proctor
19 Hospital. If you folks would introduce yourselves, spell
20 your name for the Recorder, and then we will swear you in.

21 MR. MACEK: My name is Paul Macek (spells
22 name), President and CEO of Proctor Hospital.

23 MR. ARMSTRONG: Roger Armstrong, Chief
24 Financial Officer for Proctor Hospital. (Spells name)

1 MS. NG: Edna Ng, Manager of Mental Health
2 Services at Proctor Hospital. (Spells name)

3 MR. HICKS: Mark Hicks (spells name), and I've
4 been consulting with Proctor on this project.

5 MR. ZEHR: Eric Zehr, Vice-President,
6 Ancillary Services at Proctor Hospital (spells name).

7 CHAIRMAN GALASSIE: Thank you. And we'll
8 swear you all in.

9 (Oath given)

10 CHAIRMAN GALASSIE: Michael, would you like
11 to give our State report?

12 MR. CONSTANTINO: Thank you Mr. Chairman.

13 The applicant, Proctor Community Hospital, is
14 proposing to discontinue 15 skilled nursing beds in its
15 30-bed, skilled nursing unit and establish an 18-bed,
16 inpatient, AMI geriatric care unit at Proctor Hospital in
17 Peoria, Illinois. The cost of the project is approximately
18 \$640,000. The anticipated project completion date is
19 December 31st, 2011. I believe the report reflected
20 October. This should be December 31st, 2011.

21 There is an excess of 19 AMI beds in the HSA
22 2, Acute Mental Illness Planning Area. We also note that
23 the applicant failed to provide the required zip code
24 information. Therefore, we could not determine whether or

1 not the proposed project would provide service to the
2 planning area residents. The applicant also provided
3 referral letters, indicating 89 individuals would be
4 referred for the proposed service. However, this level of
5 referral does not justify the number of beds being
6 requested.

7 We can find no evidence that this addition of
8 category of service would improve access, and it appears
9 that there is an under utilization of existing providers in
10 this planning area. There are four facilities that service
11 that area that are operating under the target occupancy of
12 85 percent.

13 Thank you, Mr. Chairman.

14 CHAIRMAN GALASSIE: Thanks, Mike.

15 MR. SEWELL: Mr. Chairman, could I ask Mike?

16 CHAIRMAN GALASSIE: Yes, please do.

17 MR. SEWELL: What does a discontinuation do to
18 the skilled bed inventory in the area?

19 MR. CONSTANTINO: It reduces it.

20 MR. SEWELL: I know, but --

21 (Laughter)

22 CHAIRMAN GALASSIE: The Board is not used to
23 that.

24 MR. SEWELL: I mean, is there excess capacity

1 for skilled beds, or do we know?

2 MR. CONSTANTINO: Right off the top of my
3 head, I don't know, sir.

4 MR. URSO: Mr. Sewell, it says in the State
5 Agency Report it will increase the current access of AMI
6 beds -- are you talking about AMI?

7 MR. SEWELL: No, skilled, the beds that are
8 discontinued.

9 MR. URSO: I'm sorry. I don't think we have
10 that.

11 CHAIRMAN GALASSIE: Mike, could you just
12 share a little more information on the impact of our
13 applicant not submitting zip code information.

14 MR. CONSTANTINO: We're required to determine
15 if the proposed project would serve the residents of the
16 planning area, and we couldn't determine from the referral
17 information they provided to us which area -- what zip code
18 these residents lived in. So, one of our criteria is we're
19 supposed to determine if the project is going to provide
20 service to the planning area residents.

21 CHAIRMAN GALASSIE: I just wanted to make sure
22 the Board is aware of that. Thank you.

23 And who will be speaking?

24 MR. MACEK: Good afternoon. My name is Paul

1 Macek, and I'm the President and CEO of Proctor, and with
2 us today is our team who was involved in preparing this
3 application.

4 First of all, I want to say thank you very
5 much for the opportunity to be here and present this
6 information, and one of the things that I think is
7 important to point out is that we would like to draw the
8 distinction for the Board between an Acute Mental Health
9 Illness bed and a geropsych bed. If you think about the
10 acute mental health -- or Acute Mental Illness bed, really
11 what you're talking about are beds that are licensed to
12 take care of anybody 18 to 80, 18 to 90 years old. So,
13 that bed can be used for any age group. In the case of the
14 geropsych bed, what we're talking about is creating a
15 designated, distinct unit for our geriatric patients with a
16 combination of psychiatric disorders as well as medical
17 disorders. So, the principal premise here is to be able to
18 take care of elderly patients in a designated unit that
19 have both a mental health problem as well as another
20 illness, and we think that the data and the experience with
21 these units suggests that you can reduce a lot of
22 readmissions for patients with these comorbid conditions.
23 You can treat patients in a much more cost-effective
24 fashion with patients with these conditions.

1 So, if you can think about the beds -- I like
2 to draw the analogy, with hospital beds we're licensed at
3 Proctor for 200 beds, and we have a lot of different kinds
4 of beds. We have ICU beds, we have pediatric beds, we have
5 maternity beds, we have surgical beds, et cetera. So,
6 we're talking about here creating a distinct unit to take
7 care of these particular patients with these particular
8 types of diagnoses. We have received a significant number
9 of letters of support from -- including the largest
10 competing hospital in the area, together with other
11 providers who see the need for this service, because right
12 now patients that require these services have to leave
13 town, and I can think of one particular example of Lutheran
14 Hillside Village in Peoria where they had to transfer
15 patients to Chicago to get treatment for these types of
16 patients. So, what we're attempting to do is provide this
17 service locally and do it in a very cost-effective way.

18 The final point I'd ask you to consider is
19 that as we go through our strategic planning process, we've
20 identified that the single biggest segment of the
21 population in our 8 to 10-county service area that is
22 growing is the 65-plus population, and that 65-plus
23 population is expected to grow about 20 percent over the
24 next 10 years. So, the need of these types of services,

1 specifically for the elderly population with both the
2 mental health and medical condition, is going to continue
3 to grow. So, we appreciate your consideration for our
4 application.

5 CHAIRMAN GALASSIE: Thank you.

6 MS. OLSON: May I ask a question?

7 CHAIRMAN GALASSIE: Sure.

8 MS. OLSON: If I'm correct in reading here in
9 the report, the closest committed geriatric AMI unit is 49
10 miles away.

11 MR. ZEHR: We do not believe that's a
12 distinct -- that's a geriatric unit.

13 MS. OLSON: It's specifically geriatric, and
14 that's the closest one? I'm sorry, you lost me.

15 MR. MACEK: It's the closest hospital that
16 provides geriatric psych services.

17 MR. CONSTANTINO: Mr. Chairman, I want to make
18 one clarification. We don't make a distinction regarding
19 these AMI beds. We don't distinguish between geriatric and
20 adolescent in our calculations.

21 CHAIRMAN GALASSIE: Thank you.

22 MR. SEWELL: I think that was going to be my
23 question. There is no category of service called
24 "geriatric psychiatric care" with respect to our rules?

1 MR. CONSTANTINO: No, sir.

2 MR. SEWELL: But in the real world, is there
3 such a thing that is recognized as having a different
4 implement of staffing or admissions? Do the professional
5 societies, for instance, recognize these?

6 MR. ZEHR: That's provided through the Center
7 for Medicaid Services. CMS provides that certification for
8 a unit such as that. This unit would be different from the
9 unit that's 49.9 miles away in that these folks will not
10 only be geriatric, psychiatric patients, but also be
11 medically compromised.

12 MR. MACEK: To your point, we have a list of
13 19 hospitals in the state of Illinois that provide specific
14 designated areas for geriatric patients, that's correct.

15 MR. SEWELL: Another question, please,
16 Mr. Chairman?

17 CHAIRMAN GALASSIE: Yes.

18 MR. SEWELL: I was just going to ask, should
19 this unit be established, would you exclusively have
20 geriatric patients in that unit and no other age category
21 of patients?

22 MR. ZEHR: Right. That's part of the
23 distinction.

24 CHAIRMAN GALASSIE: Dr. Burden?

1 MR. BURDEN: I'm just curious about this
2 hospital profile that I've reviewed here previously. It's
3 amazing. You've got populations, essentially 94 percent
4 white by demographics, 4.2 percent Medicaid. Where is it
5 located in Peoria? That's an unusual demographic stats
6 here that I don't recognize.

7 MR. MACEK: It's located on the north end of
8 Peoria.

9 MR. BURDEN: You've got Methodist and teaching
10 hospitals, which have much different demographics.

11 MR. MACEK: Correct.

12 MR. BURDEN: Of course, they're larger. Is
13 there any data about the med/surg occupancy levels? I'm
14 looking for that. I don't see that. Could you answer?
15 Just checking on the census.

16 MR. MACEK: On the medical/surgical side, that
17 occupancy will vary from 50 to 75 percent, depending on the
18 time of the year.

19 MR. BURDEN: There aren't many places looking
20 for AMI beds. Most that go on in the city, the reverse is
21 happening. They want to get out of that business.

22 MR. MACEK: Again, one of the characteristics
23 about Proctor that I think is important to take into
24 consideration is that about 60 percent of the patients we

1 see are Medicare patients, which is substantially higher
2 than the other two organizations in town. So, what we're
3 talking about is really a continuation of our focus around
4 the elderly patient and services that they need today and
5 going into the future. We have a skilled nursing unit; we
6 do a lot of orthopedic work. The behavioral health and the
7 geropsych component is very consistent with the whole
8 continuum of services that we see ourselves providing in
9 the community.

10 MR. BURDEN: Thank you.

11 MR. CARVALHO: Mr. Chairman?

12 CHAIRMAN GALASSIE: Sure, Dave.

13 MR. CARVALHO: One of the features of the way
14 our need determinations work is that when an applicant is
15 approved for a category of service, it goes into the
16 inventory, and that gets measured against future
17 applications. So, although the intent is to use the AMI
18 beds for the elderly, they will go into our inventory as
19 AMI beds and, therefore, act in a way as a deterrent to
20 others, because the need will be reduced by that much. So,
21 my question is, why is it that you are choosing to use the
22 AMI beds for the elderly population?

23 MR. MACEK: I'll make a comment on that, and
24 then Rick and others can comment on it as well. The reason

1 we're focused on that is because of the significant need
2 for this service that has been expressed by long-term care
3 facilities, primary care physicians, and others throughout
4 the community. I think another example of support for that
5 and the need for it is the fact that our largest
6 competitor, St. Francis, is very supportive of the
7 application. So, there is a need that is not being met in
8 the community, and that's the reason that we're focused on
9 specifically -- again, it might be a matter definition
10 whether it's acute or geriatric, but what we're talking
11 about is a unit specifically designed for the geropsych
12 patient with medical conditions.

13 MR. SEWELL: Currently, do you have geriatric
14 patients with psychological diagnoses or disorders in your
15 skilled beds that you're going to discontinue? I mean,
16 right today?

17 MR. ZEHR: Not that I'm aware of. Certainly
18 there could be folks with maybe a depressive diagnosis but,
19 again, those aren't the same. Those patients that will be
20 appropriate for a distinct geropsych, medically-compromised
21 unit would not be appropriate for a skilled nursing bed.

22 MR. SEWELL: All right.

23 MR. CONSTANTINO: Mr. Chairman?

24 CHAIRMAN GALASSIE: Go ahead.

1 MR. CONSTANTINO: I've got a response for
2 Mr. Sewell on the number of beds. That would result in an
3 excess of 23 long-term care beds in that planning area,
4 with the discontinuation of the 15.

5 MR. SEWELL: So that means there are 38 now?

6 MR. CONSTANTINO: Right. With the
7 discontinuation, that would result in 23, yeah.

8 CHAIRMAN GALASSIE: I think I have a relevant
9 question, at least to me it is. Would you entertain a
10 condition to limit these 18 beds to geriatric AMI?

11 MR. ZEHR: Yes, we would. Our focus is on age
12 56 and over. Again, some folks under 65 may be on SSI. By
13 far, the vast majority of these folks will be on Medicare.

14 CHAIRMAN GALASSIE: I think from what I'm
15 hearing, the Board will be more comfortable with that
16 condition.

17 MS. OLSON: Careful what you're calling
18 geriatric.

19 (Laughter)

20 CHAIRMAN GALASSIE: Any other questions from
21 the Board?

22 MR. CARVALHO: Actually, yes. What is the
23 reimbursement difference? It sounds like we're proposing
24 to limit them to only serve the better-paying patients,

1 which they probably would be happy to do on their own. Is
2 the reimbursement different for the elderly AMI versus the,
3 I guess, Medicaid AMI?

4 MR. MACEK: I can tell you overall that our
5 Medicare reimbursement runs about \$0.81 of our cost.

6 MR. CARVALHO: That may be a reflection of
7 your costs, too. What is the reimbursement under Medicare
8 versus Medicaid for AMI?

9 MR. MACEK: Again, the Medicare program will
10 reimburse higher than the Medicaid program, and that's
11 consistent whether or not it's an AMI patient or a general
12 medical patient or a patient coming in the emergency room.

13 MR. CARVALHO: Right. I guess -- is my
14 observation correct? With the proposed limitation, it's
15 going to limit you to serve patients who are better
16 reimbursed than the general population?

17 MR. MACEK: No, I don't think that's the case,
18 because you're going to have Medicaid patients who are 55
19 years and older as well as Medicare patients 55 years and
20 older.

21 MR. CARVALHO: The ones under 55 are not going
22 to be Medicare.

23 MR. MACEK: That's correct, and again, the
24 whole purpose of the unit is to serve the elderly

1 population. The intent here is not to serve the 18, 30,
2 40-year-old patient.

3 CHAIRMAN GALASSIE: Are you comfortable with
4 that, David? I put that out there because of the excess
5 bed issue. If it's counter-productive --

6 MR. CARVALHO: I don't need to be comfortable.

7 MR. SEWELL: Couple of things. But it's
8 not -- this condition, it's not going to change anything,
9 because we don't have geriatric psychiatric beds category
10 of service.

11 I guess I wanted to hear from Staff a little
12 more about what the Chairman raised about this data that
13 was not submitted, the zip code data.

14 MR. CONSTANTINO: Yes. We are required to get
15 referral letters for all of these projects, and in this
16 case, the referral letters didn't contain zip code data
17 which tells us where these patients are coming from. We
18 review the zip code data, and we look for -- at least 50
19 percent of the patients have to come from that planning
20 area in the acute mental illness planning area. In this
21 case, we didn't have that information, and I just note that
22 for the Board.

23 MR. ZEHR: If I could respond, on page 75 of
24 our application there is a map that includes the top ten

1 zip codes for Proctor Hospital. So, it's maybe kind of
2 embedded in there, but it's clearly stated what those are.

3 CHAIRMAN GALASSIE: Well, I guess it's not
4 clearly stated by our Staff's perception, so you might want
5 to be aware of that.

6 I'm going to -- so, I think we're back to not
7 necessarily needing the condition in terms of geriatric,
8 AMI beds. So, I will propose a motion to approve Project
9 11-063 for the establishment of an 18-bed Acute Mental
10 Illness category of service at Proctor Hospital in Peoria,
11 Illinois.

12 MR. EAKER: So moved.

13 MR. BURDEN: Second.

14 MR. DART: Motion made by Mr. Eaker, seconded
15 by Dr. Burden.

16 Dr. Burden?

17 MR. BURDEN: I'm somewhat confused about this
18 targeting an age group. This is the first time I've
19 encountered this information in my five years with this
20 appointment to the Board. Other than that -- I suppose I
21 would have to say okay, even though we certainly
22 recognize -- I certainly recognize that there has been some
23 supportive levels from prominent politicians, citing the
24 need for this area. Although I'm a little confused, I'll

1 vote a very careful yes.

2 MR. DART: Mr. Eaker?

3 MR. EAKER: Yes.

4 MR. DART: Justice Greiman?

5 MR. GREIMAN: Yes.

6 MR. DART: Mr. Hayes?

7 MR. HAYES: Yes.

8 MR. DART: Mr. Hilgenbrink?

9 MR. HILGENBRINK: Yes.

10 MR. DART: Ms. Olson?

11 MS. OLSON: Yes, and I'd just like to say the

12 reason I'm saying yes is because it's very obvious to me

13 that you can't put an 18-year-old psychiatric patient in

14 the same room as an 80-year-old psychiatric patient, and

15 there's obviously a rule.

16 MR. DART: Mr. Sewell?

17 MR. SEWELL: Yes. I think we're going to have

18 to do more work on this whole issue of geriatric

19 psychiatric beds.

20 MR. DART: Chairman Galassie?

21 CHAIRMAN GALASSIE: Yes.

22 MR. DART: That's eight votes in the

23 affirmative.

24 CHAIRMAN GALASSIE: Motion passes.

1 Congratulations. Good luck.

2 Now we are moving into Item 11-039 and, again,
3 rather unusual by our standards, but we have discussed this
4 with the applicants and amongst the Board. All 15 of these
5 applications involve Resurrection and Provena Hospital
6 systems. What we are going to propose doing is having the
7 systems come to the table and introduce yourselves and
8 spell your names and be sworn in, giving us your
9 presentations regarding these applications. We will then
10 take each application, a vote on each application
11 individually. So, if you'll remain at the table, we would
12 appreciate that, so if there are any questions by Board
13 members on individual applications. If not, there will be
14 a motion and subsequent decision on each application.

15 Are we in agreement with that process?

16 (Pause)

17 CHAIRMAN GALASSIE: Let the record show the
18 applicants are in agreement with that process. That having
19 been said, we are now addressing Item 11-039, United
20 Samaritan Medical Center in Danville. If you folks could
21 introduce yourselves and spell your names.

22 MR. WIEBKING: My name is Guy Wiebking (spells
23 name).

24 MS. IMLER: Sister Mary Elizabeth Imler

1 (spells name).

2 MS. BRUCE: Sandra Bruce (spells name).

3 (Oath given)

4 CHAIRMAN GALASSIE: Thank you very much.

5 And I'm sorry, Board, I also forgot to mention
6 that we will have a Staff report given for each individual
7 application as well.

8 Michael, if you will please, for 11-039.

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

10 The applicants, Resurrection Healthcare
11 Corporation, Provena Health, and Cana Lakes Health Care,
12 are requesting a change of ownership of a 174-bed acute
13 care hospital located in Danville, Illinois. The fair
14 market value of the project is approximately \$170 million.
15 They anticipate a completion date of February 1st, 2012.
16 Public hearing was held on August 17th. We received a
17 number of support letters, no opposition letters. This
18 project is before you because it's a change of ownership,
19 it's a change of control of a healthcare facility.

20 CHAIRMAN GALASSIE: And one of fourteen more
21 to follow?

22 MR. CONSTANTINO: Yes, sir.

23 CHAIRMAN GALASSIE: Thank you.

24 If you would please address the Board.

1 Welcome.

2 MR. WIEBKING: Thank you very much,
3 Mr. Chairman. Good afternoon. My name is Guy Wiebking,
4 and I am the President and CEO of Provena Health. Seated
5 to my left is Sandra Bruce, the President and CEO of
6 Resurrection Healthcare Corporation, and we are also joined
7 by Sister Elizabeth Imler, who is here today representing
8 the five congregations of Women Religious that sponsor
9 Provena and Resurrection. We thank you for the opportunity
10 to appear before you today. Because of the positive
11 findings in each of the fifteen State Agency Reports, our
12 presentation will be brief.

13 Provena and Resurrection are proposing the
14 merger of two Illinois-based, Catholic healthcare systems
15 through a not-for-profit corporate reorganization. We view
16 this as a merger of equals. Neither system is taking over
17 the other. And aside from the costs of implementing the
18 merger transaction itself, there is no purchase price or
19 other capital expenditure associated with this merger.

20 Should the merger be approved, I will become
21 the first Chairman of the Board of the combined system,
22 parent organization. Sandra Bruce will become the first
23 President and CEO of that organization. The core goal of
24 the proposed merger is to advance the shared mission of

1 Resurrection and Provena in an era that demands innovation
2 by healthcare providers in order to adapt to healthcare
3 reform and other external realities. The system merger
4 will offer the populations and communities historically
5 served by Provena and Resurrection access to healthcare
6 facilities that are poised to meet these challenges now and
7 into the future. The merger is intended to preserve
8 accessibility to Catholic-sponsored healthcare through an
9 Illinois-based healthcare system that vests significant
10 programmatic and operational autonomy in each local
11 hospital community. It will improve financial viability
12 and administrative efficiencies. It will enhance our
13 already robust efforts at clinical excellence through
14 combined quality improvement and patient safety
15 initiatives. It will improve patient, employee and medical
16 staff satisfaction through a shared culture and integrated
17 leadership. And, finally, it will help enhance access to
18 healthcare for all of our patients, including our medically
19 under served patients.

20 The discussions between the sponsoring
21 congregation and the boards at Provena and Resurrection
22 that have led to our appearance before you today began
23 nearly a year ago. Through exhaustive discussion, due
24 diligence and discernment processes, we have come to

1 appreciate our unique compatibility that, with your
2 approval, will result in one of the most comprehensive
3 Catholic-sponsored healthcare systems in the Midwest. The
4 combined system will provide a continuum of services from
5 outpatient screening and diagnostic programs to inpatient
6 care, to psychiatric programs, rehabilitation programs,
7 long-term care facilities, and a wide variety of
8 community-based programs. These services will be provided
9 across northern and southern Illinois in diverse inner
10 city, urban and rural communities that include medically
11 under served areas and working-class communities.

12 The applications before you today address
13 thirteen hospitals, one ambulatory surgery treatment
14 center, and one end-stage renal dialysis facility.
15 Provena's hospitals are located primarily in the
16 communities to the west of Chicago and in central Illinois.
17 Resurrection's hospitals are located in Chicago and the
18 communities to the north of Chicago. There is no overlap
19 between the current service areas in the two systems. Our
20 combined service area population would be approximately
21 four and a half million people, and in addition to the
22 hospitals, the ambulatory surgery treatment center and the
23 end-stage renal dialysis facility that you'll be voting on
24 today, the system will also include 28 long-term care and

1 senior residential facilities, 50 primary care and
2 specialty outpatient clinics, and 6 home healthcare
3 agencies. Following the merger, we will be working with
4 nearly 5,000 physicians and have more than 22,000 employees
5 from Evanston on the north end of the system to Danville
6 and Champaign-Urbana on the south end of the system.

7 With that bit of introduction, Sandra Bruce
8 will discuss the manner in which the merger will be
9 implemented and how services will be provided.

10 CHAIRMAN GALASSIE: Thank you.

11 MS. BRUCE: Thank you. Through the proposed
12 transaction, the two systems will combine under the control
13 of a single, not-for-profit corporation. The new system
14 will become the shared corporate parent of Resurrection
15 Healthcare and Provena Health. As the combined system
16 parent, the new entity will have authority to make certain
17 key decisions on behalf of the system and also will have
18 the ability to provide and coordinate resources needed to
19 provide high-quality care and service by the hospitals and
20 the other facilities throughout the system. The
21 not-for-profit structure we're describing will allow us to
22 adopt to medical healthcare reform while not compromising
23 the mission and values inherent in the religious
24 sponsorship of our healthcare facility. It will also allow

1 us substantial programmatic and operational autonomy to
2 remain at each local hospital in the community. The
3 organizational structure I've described is detailed in the
4 System Merger Agreement that was provided to you with our
5 original filing.

6 Consistent with your guidelines and as
7 reflected in your Staff reports, patient access to
8 healthcare services will not be diminished nor compromised
9 by the merger. In fact, we believe the merger will better
10 enable us to provide expanded healthcare access. We expect
11 that the current healthcare facilities and major clinical
12 programs will be maintained for at least two years. We
13 also do not anticipate significant changes in clinical or
14 hospital administrative staffing for at least two years,
15 aside from the routine changes that are associated with
16 day-to-day hospital operations.

17 The merger will have a positive effect on
18 healthcare access to the medically under served. As
19 described in the individual CON applications and in the
20 supplemental material submitted to the Board, we have
21 evaluated each system's individual charity care policies
22 and have developed a proposed consolidated policy that we
23 intend to implement system-wide. The new charity care
24 policy incorporates the best aspects of both of the

1 existing policies into what will become one of the most
2 generous charity care policies in the state of Illinois.
3 The policy has also been recently reviewed and positively
4 received by the Illinois Attorney General's office, and
5 we're pleased to report that no changes to the proposed
6 policy have been requested by the Attorney General's
7 office.

8 One core priority of this merger is to ensure
9 that our healthcare facilities remain part of the fabric of
10 these local communities through involvement in local
11 community programs, and I want to give you a couple of
12 examples of those programs as they exist today. In
13 Danville, the Provena Hospital participates in the Young
14 Women Aware program, a program that focuses on high school
15 completion, college entry, and pregnancy prevention. On
16 the west side of Chicago, two Resurrection hospitals,
17 Resurrection Medical Center and our Lady of the
18 Resurrection Medical Center, sponsor programs that address
19 childhood nutrition, diabetes, and obesity. And in Urbana,
20 the Provena Hospital supports the Medicare 100 program,
21 which provides healthcare services to low-income Medicare
22 beneficiaries. We are committed to maintaining and expanding
23 what I have referred to as examples of the broad base of
24 community services that are throughout both organizations

1 today, and we want to continue and make sure that the
2 programmatic decisions around those programs are done and
3 made at the local level, with input from the community.

4 At this point and before we answer questions,
5 Sister Mary Elizabeth Imler will address the system's
6 merger from the perspective of the sponsor congregations.

7 MS. IMLER: Thank you, and from my vantage
8 point with the sun shining over your shoulder, I reflect
9 back to you a good afternoon.

10 (Laughter)

11 MS. IMLER: I'm a member of the San Franciscan
12 Sisters of the Sacred Heart religious congregation. I most
13 currently am serving as the Chairperson for Provena Health
14 member body. So, I'm here today on behalf of the member
15 body of Provena Health, which includes my own congregation,
16 the San Franciscan Sisters of the Sacred Heart, the
17 Servants of the Holy Heart of Mary, and the Sisters of
18 Mercy of the Americas West Midwest community; also, on
19 behalf of the sponsorship board of the Resurrection
20 Healthcare, which includes the Sisters of the Holy Family
21 of Nazareth and the Sisters of Resurrection.

22 As you can imagine, the merging of our
23 healthcare systems is not something that we took lightly.
24 While the potential benefits of doing so became evident

1 early in our discussions over a year ago, the actual
2 decision to proceed was not made without thorough
3 evaluations by our management teams and outside
4 consultants. We engaged in a lengthy process and, myself
5 and all of the Sisters behind us and before us in
6 reflection and prayer. Hence, we as congregations are now
7 convinced that the combining of our systems will not only
8 promote the provision of Catholic healthcare, but will
9 provide our existing systems with a stronger foundation on
10 which to do so. This merger has received tremendous
11 support from both the provider community and the public, as
12 witnessed by the fifteen public hearings that were held on
13 these applications. We were particularly grateful for the
14 letters of support from His Eminence Francis Cardinal
15 George, Archbishop from Chicago, from the Catholic Bishops
16 who oversee the diocese in which Provena hospitals are
17 located, and from numerous local, state and federal elected
18 officials, community groups and members of the public, who
19 have looked to Resurrection and Provena for their
20 healthcare needs over the years.

21 It seems fitting that we close by thanking you
22 and your staff for your diligence and effort in conducting
23 these public hearings and in evaluating the sheer volume of
24 information we have provided to you in connection with

1 these applications. We appreciate the opportunity to
2 appear before you today and certainly would be happy to
3 answer any questions that you may have.

4 CHAIRMAN GALASSIE: Thank you, Sister
5 Elizabeth.

6 I'll open it to the Board for questions.

7 MR. GREIMAN: When you have a central
8 authority controlling the seventeen or thirteen -- whatever
9 hospitals, the first speaker said the healthcare will be
10 better. Why will healthcare be better? What makes the
11 management distant from the giving of the services better?

12 MR. WIEBKING: Well, there's several reasons.
13 Number one, with these systems coming together, the ability
14 for us to interact in our quality and patient safety
15 initiatives from a best practice standpoint will allow it
16 to be not only shared but supported and promoted, and the
17 system governance itself helps in that endeavor.

18 MR. GREIMAN: Can we assume these two very
19 responsible and coveted groups of enterprises are doing
20 that currently? Aren't they?

21 MR. WIEBKING: I think, Judge, that there is no
22 doubt about that, but there's always room that you are
23 pursuing excellence, and that's a process that just doesn't
24 stop, and this gives us a realistic way that is somewhat of

1 a booster rocket that you wouldn't have individually. It's
2 not to say that you can't have high-quality healthcare
3 without it. All I'm simply saying is that it gives us an
4 opportunity to enhance on that.

5 MR. GREIMAN: Okay.

6 CHAIRMAN GALASSIE: Rob, do you have a
7 question?

8 MR. EAKER: I have a question. First of all,
9 I'd like to commend you on your charitable care policy that
10 you've adopted. I have a question, and this is from my own
11 inability to comprehend. At the bottom of page 1, there's
12 a statement about poverty guidelines and after a \$300
13 threshold per encounter is collected. What does "per
14 encounter" actually mean?

15 MS. BRUCE: I'll have to find the policy,
16 because I believe that related to people who had insurance
17 whose balance -- and they had a remaining balance. So, if
18 I'm admitted to the hospital and insurance pays and I'm
19 working, I can be eligible for the charity care policy
20 after paying the first \$300 of that remaining balance.

21 MR. EAKER: The part that stumps me is the
22 "per encounter".

23 MS. BRUCE: And the encounter has to do with
24 per admission.

1 MR. EAKER: Per billing.

2 MS. BRUCE: If you were admitted three times,
3 that would be \$300 for each of those.

4 MR. EAKER: Each episode.

5 MS. BRUCE: Yes.

6 MR. EAKER: Okay. Thank you. I was just
7 unclear about that.

8 CHAIRMAN GALASSIE: Dr. Burden, I think, has
9 a question.

10 MR. BURDEN: I heard a statement about a --
11 maybe a moratorium isn't a correct word. Previously, when
12 there has been sale or combinations of institutions,
13 hospitals, there's been concern from the public, union
14 voices, regarding immediate changes in personnel, which
15 obviously would allow the respected institutions that have
16 joined to decrease costs. Does a moratorium with this
17 merger -- which is the first time we've encountered this
18 large, of course, this number of institutions -- allow you
19 to approach the union without concern? You have two years
20 before you effectively manage what might have been
21 considered to be an area that needed to be reduced, reduce
22 the costs that might be forthcoming with the new healthcare
23 law coming. I heard the words "two years". I didn't see
24 it in print, but it probably is. Is that my understanding,

1 that you have been to a degree held hostage by the unions,
2 or is that something that you agreed to without incurring
3 their wrath, that you don't let anyone go before two years?

4 MS. BRUCE: I'm going to tell you straight up
5 what the deal is.

6 MR. BURDEN: I like it straight up.

7 MS. BRUCE: This merger is designed to do a
8 number of things: Strengthen Catholic healthcare, improve
9 our financial performance, enhance our quality and our
10 clinical integration, and, hopefully, really enhance our
11 ability to partner with physicians. The part of getting to
12 the financial goals is getting some efficiencies where we
13 have some duplications, where we scoped this project to
14 attain those efficiencies at the corporate level, not at
15 the sites where care is delivered. We made no promises or
16 commitments to unions, that I'm aware of. In fact,
17 (inaudible) has 80 employees out of 12,000 who don't even
18 belong to a union. So, we've not made a commitment there,
19 but we will. As we bring the corporate functions together,
20 there will be jobs lost, because we have duplication of all
21 of those functions at the corporate level. Down at the
22 site level, we have made no plans to take people out of
23 their jobs.

24 MR. BURDEN: Perhaps it would be premature of

1 me to predict, but I live in a community proximate where
2 Resurrection Healthcare exists, and I'm aware, as a retired
3 physician, of many friends who work at that institution,
4 that the unnamed union has been adamant for some time at
5 both St. Francis and Resurrection. I think it's caused a
6 certain amount of anxiety for a lot of the nuns that have
7 been involved in those institutions, since I worked in the
8 community up until ten years ago. So, I'm looking down the
9 line how you resolve those problems without marching in the
10 streets, placards, tear down this and that thing. This is
11 something I would hope you could avoid with your two years
12 moratorium, hopefully.

13 MS. BRUCE: We'd truly like to avoid that. As
14 you know, Resurrection for nine years has been the subject
15 of what's called a corporate campaign by a union, and in a
16 corporate campaign, the enterprise has to hand all of its
17 employees over to the union without the employees having a
18 secret ballot election. So, our sponsors and our
19 governance have said all along, that violates our values.
20 Our employees have a right to a secret ballot election, and
21 so we have not turned over our employees without a vote.
22 Recently, this past fall, an election was held at Our Lady
23 of the Resurrection in the bargaining unit of RN's, and the
24 employees -- 95 percent of that bargaining unit voted, and

1 they -- 62 percent of them said, "We do not want to be
2 represented by a union." Had the vote gone the other way,
3 Resurrection would have stepped up, honored our employees
4 wishes, and entered into a contract.

5 CHAIRMAN GALASSIE: I'm not sure -- I think,
6 Ms. Bruce, you made the comment that you wanted to assure
7 input from the local level, and I'm sure you do.

8 MS. BRUCE: Yes.

9 CHAIRMAN GALASSIE: And want to continue to.
10 Both Resurrection and Provena are outstanding
11 organizations.

12 And you might want to discuss this before
13 answering it, but would you entertain a condition -- and
14 understand, I'm one of the public health people here -- a
15 condition that you would invite your local public health
16 department -- typically, most often county -- to
17 participate in your annual planning process or your local
18 community planning? In other words, what I'm asking is,
19 you want to assure local community input. I could have
20 asked you how you intend to do that. But I'm proposing a
21 condition that would, in my mind, help assure local
22 community input, that when you sit down -- and having
23 worked for many years at the local level with many
24 hospitals, I think it's to everyone's advantage if a local

1 health department is a partner at that table. My
2 experience, typically hospitals enjoy that, but I say
3 "typically," because that's not always the case.

4 So, I guess I would encourage you to consider
5 a condition that you would agree to invite your local
6 health department at fifteen various locations to be a
7 partner in your local community input process. Anyway, I
8 think --

9 MS. BRUCE: We'll definitely agree with the
10 premise, and Resurrection has a very rigorous process for
11 determining the needs of the community and gaining input
12 from a variety of community agencies, and each of the
13 Resurrection ministries has a community board, separate
14 from the governance board, that's designed to keep us aware
15 of community need and also a place for local CEO's to
16 bounce off ideas, you know, "Here's a program we're
17 thinking about starting." So, obviously, as a public
18 health department, very aware, I've met with Cook County
19 officials on numerous occasions, including Stroger, because
20 many of our markets overlap and we're dealing with the same
21 kinds of issues. Would hate to start a precedent of making
22 a contingent a piece to allow this merger to come together,
23 but would commit to you that that would be a practice I
24 would expect everyone of our communities to follow.

1 CHAIRMAN GALASSIE: I would love that to be a
2 precedent.

3 MS. BRUCE: Pardon?

4 CHAIRMAN GALASSIE: I would love that to be a
5 precedent, that you would have a local health department at
6 your planning meetings.

7 MS. BRUCE: And we should do that.

8 CHAIRMAN GALASSIE: I'm sure you intend to do
9 that, but you also have fifteen different boards with
10 fifteen different permits and fifteen different egos,
11 perhaps. So, I'm hoping there is some further level of
12 assurance that you would commit at your fifteen local
13 boards, if I'm saying that correctly, to invite a public
14 health presence. That's part one of my question.

15 Part two of my question is would you be
16 willing to give us some verbal feedback, at least if
17 nothing else a year from now, from your -- just a simple
18 statement, did your fifteen local community groups meet,
19 and if they did meet, was there a public health presence
20 when they met?

21 MS. BRUCE: I would love to do that.

22 CHAIRMAN GALASSIE: I would personally
23 appreciate that.

24 MS. BRUCE: I'd love to say, "Here is how we

1 handled it; here is the process we used at each community."
2 It's absolutely essential, given health reform, that every
3 one of our geographies know and understand the needs of
4 their communities, and public health is as much data and
5 information as any agency.

6 CHAIRMAN GALASSIE: So, you would submit that
7 to us in writing?

8 MS. BRUCE: Yes.

9 CHAIRMAN GALASSIE: I, for one, greatly
10 appreciate that.

11 Questions?

12 MR. JONES: Your charity care policy
13 specifically mentions changes in the Internal Revenue Code
14 that were made by the Affordable Care Act. So, you're
15 probably well aware that charitable hospitals will now be
16 required to do a Community Health Needs Assessment.

17 MS. BRUCE: Yes.

18 MR. JONES: The Community Needs Assessment
19 that you're going to have to do is parallel to, possibly
20 identical to, what local health departments do to be
21 certified by the State Department of Public Health. So, it
22 would be in your advantage and to the advantage of the
23 people you serve to do what Dale has proposed, but embody
24 that within a partnership to do that Community Health Needs

1 Assessment. So, if they can hook up the timing when the
2 local health department has to do its IPLAN process and you
3 do your Community Health Needs Assessment, it would be a
4 harmonious thing that would achieve two purposes at once.

5 So, I think if you come back here with a plan,
6 what the Board would like to hear would be how have you
7 aligned your Community Health Needs Assessment with the
8 local IPLAN.

9 MS. BRUCE: Okay. We have a process for doing
10 the Community Needs Assessment now, which would include
11 that, with the exception of the last piece, I think, which
12 aligns with what?

13 MR. JONES: The IPLAN is the Illinois Process
14 for Local --

15 MR. SEWELL: -- Assessment of Need.

16 MR. JONES: Illinois Project for Local
17 Assessment of Need, and I will probably defer any further
18 questions about that to David Carvalho, because that
19 process is managed within his domain at the Department of
20 Public Health. Anyway, if you have questions about IPLAN,
21 connect with David or connect with me and I'll connect with
22 David.

23 MS. BRUCE: So --

24 CHAIRMAN GALASSIE: I'm sorry. I didn't mean

1 to interrupt you. Hearing a commitment to have local
2 public health involved in their planning process -- and I
3 certainly anticipated that they would want to do that. I
4 think local public health will have the ability to
5 dialogue, if they already aren't.

6 MR. JONES: Absolutely, but right now Public
7 Health is not aware of the change in the Internal Revenue
8 Code either. So, if you go to them and say, "Here's what
9 we have to do; we know you're doing an IPLAN," that's going
10 to open the door that isn't open in a lot of
11 communications.

12 CHAIRMAN GALASSIE: Well, shouldn't we say
13 that to local public health?

14 MR. JONES: Sure, go ahead.

15 (Laughter)

16 MR. SEWELL: I love all of this public health
17 talk. Greater -- no, not greater -- Cana Lakes Healthcare
18 Corporation is the Board of Directors of that corporation
19 already established.

20 MR. WIEBKING: The board for the new system
21 has been established.

22 MR. SEWELL: Is there anyone on that board
23 that's not on the board of Provena or Resurrection?

24 MR. WIEBKING: We have reserved three at-large

1 positions purposely, to ensure that we have representation
2 outside both organizations. What is happening is we have a
3 board that is established with 14 to 19 people, 5 Provena
4 Health board members, 5 Resurrection Healthcare board
5 members, and then five of the Sisters, one each from the
6 sponsoring congregations, is on the initial board that has
7 not met yet.

8 MR. SEWELL: Right. Without naming names,
9 could you give sort of a broad description of what you're
10 looking for in those directors that are not already with
11 the orders or with Provena or with Resurrection? I mean,
12 like professional backgrounds, areas of interest, whatever.

13 MR. WIEBKING: Yeah. Well, we have a very
14 broad array of backgrounds that are coming with the new
15 board as it is. One of the things that will help us better
16 answer your question is when we first start meeting and see
17 the complexities of the future, the vision of the future
18 and what expertise we may not feel like we have. That will
19 drive certain decision-making processes there. But I would
20 say for sure we will attain people with healthcare
21 backgrounds and experiences that are not colored by what we
22 come from today. I mean, we're looking for a diversity of
23 opinions that helps drive, I think, better wisdom in our
24 decisions as we move forward, and, you know, the complexity

1 of healthcare and the changes that are coming are probably
2 the most concerning matter that, I think, any of us in this
3 industry have to face in the future, and trying to stay
4 attune to that and have an avid interest in it and a
5 pursuit of knowledge is a core value as well as --
6 obviously in our case, we're a Catholic healthcare
7 ministry, and being devoted to the mission and values of
8 our organization are central to board membership.

9 MR. SEWELL: The purpose of my line of
10 questioning was to get some sense of the impact that this
11 could have on your core values. So, I think that the
12 numbers that you described and the way you described it,
13 it's okay.

14 CHAIRMAN GALASSIE: Hearing no other
15 questions --

16 MR. HAYES: Mr. Chairman?

17 CHAIRMAN GALASSIE: Yes, sir, Mr. Hayes.

18 MR. HAYES: Who will appoint the board
19 members? There will be five from the different religious
20 orders, and then will they then appoint two each for the
21 other ten members?

22 MR. WIEBKING: The reserve powers in our
23 organization are the sponsoring congregations. So, we have
24 what's called a corporate member and that's ten Sisters,

1 two from each of the congregations, that have the authority
2 to appoint the board members. So, in answer to your
3 question before, those appointments have been made by the
4 corporate member for the system board.

5 MS. IMLER: I might add to that that there is
6 a nominating process that happens at the system board
7 level, and some of those five Sisters that sit on the board
8 would participate in that, so that it's not from on high a
9 pronouncement. It really comes from within that system
10 and, again, noting what is needed to move that organization
11 forward, and so it's really a affirmation by the member
12 body. Does that answer your question, Mr. Hayes?

13 MR. HAYES: Yes. Thank you.

14 CHAIRMAN GALASSIE: Hearing no other
15 questions and conferring with counsel, I'm going to propose
16 a motion that is going to include all fifteen applications.
17 All fifteen of those applications will also include the
18 contingency or the condition that we discussed in spirit,
19 of including local public health at your planning function
20 and reporting back to us in a year.

21 So, prior to making that motion, I want to
22 give Board members a moment or two, in case you had any
23 questions on -- any other questions on any of the other
24 fourteen applications that make up this entire fifteen

1 application process. That wasn't easy.

2 (Pause)

3 CHAIRMAN GALASSIE: Hearing none -- in
4 addition, we will include in the record all fifteen Staff
5 reports, not that we want to hear them from you, Michael,
6 but we want to include them in the record.

7

8 (The following are the Staff reports, as indicated, and
9 submitted by Mr. Constantino for inclusion in this
10 transcript. These Staff reports are inserted in the form
11 they were submitted to the Court Reporter.)

12

13 #11-039 -United Samaritan Medical Center

14 Resurrection Health Care Corporation, Provena
15 Health, and Cana Lakes Health Care ("the applicants") are
16 requesting a change of ownership of a 174 bed acute care
17 hospital located in Danville, Illinois. The cost of the
18 project is \$170,471,667. A public hearing was held on
19 August 17, 2011 no opposition comments were received by the
20 State Board Staff. The anticipated completion date is
21 February 1, 2012.

22

23 #11-040 - Provena Mercy Medical Center

24 Resurrection Health Care Corporation, Provena

1 Health, and Cana Lakes Health Care ("the applicants") are
2 requesting a change of ownership of a 299 bed acute care
3 hospital located in Aurora, Illinois. The cost of the
4 project is \$336,129,677. A public hearing was conducted on
5 September 7, 2011. No opposition comments were received.
6 The anticipated completion date is February 1, 2012.

7

8 #11-041 - Provena St Joseph Hospital

9 Resurrection Health Care Corporation, Provena
10 Health, and Cana Lakes Health Care ("the applicants") are
11 requesting a change of ownership of a 178 bed acute care
12 hospital located in Elgin, Illinois. The cost of the
13 project is \$344,692,667. A public hearing was conducted on
14 August 26, 2011. No opposition comments were received.
15 The anticipated completion date is February 1, 2012.

16

17 # 11-042- Provena Covenant Medical Center

18 Resurrection Health Care Corporation, Provena
19 Health, and Cana Lakes Health Care ("the applicants") are
20 requesting a change of ownership of a 210 bed acute care
21 hospital located in Urbana, Illinois. This facility is
22 currently controlled by Provena Health. The cost of the
23 project is \$267,376,667. A public hearing was conducted on
24 August 17, 2011. Letters of support were received no

1 letters of opposition and one letter of concern. The
2 anticipated completion date is February 1, 2012.

3

4 #11-043 Our Lady of Resurrection Medical Center

5 Resurrection Health Care Corporation, Provena
6 Health, and Cana Lakes Health Care ("the applicants") are
7 requesting a change of ownership of a 299 bed acute care
8 hospital located in Chicago, Illinois. This facility is
9 currently controlled by Resurrection Health Care
10 Corporation. A public hearing was conducted on August 22,
11 2011. No letters of opposition were received. The cost of
12 the project is \$215,527,925. The anticipated completion
13 date is February 1, 2012.

14

15 #11-044 Provena St. Mary's Hospital

16 Resurrection Health Care Corporation, Provena
17 Health, and Cana Lakes Health Care ("the applicants") are
18 requesting a change of ownership of a 182 bed acute care
19 hospital located in Kankakee, Illinois. This facility is
20 currently controlled by Provena Health. The cost of the
21 project is \$195,996,667. A public hearing was conducted on
22 September 16, 2011. Letters of support were received and
23 no letters of opposition were received. The anticipated
24 completion date is February 1, 2012.

1

2 #11-045 Belmont & Harlem Surgery Center

3 Resurrection Health Care Corporation, Provena

4 Health, Belmont/Harlem Surgery Center, LLC and Cana Lakes

5 Health Care ("the applicants") are requesting a change of

6 ownership of a multi-specialty ambulatory surgical

7 treatment center located in Chicago, Illinois. This

8 facility is currently controlled by Resurrection Health

9 Care Corporation. The cost of the project is \$4,838,704. A

10 public hearing was conducted on August 22, 2011. Letters

11 of support were received and no letters of opposition.

12 The anticipated completion date is February 1, 2012.

13

14 #11-046 Manteno Dialysis Center

15 Resurrection Health Care Corporation, Provena

16 Health, Cana Lakes Health Care, and Kankakee Valley

17 Dialysis Network, LLC ("the applicants") are requesting a

18 change of ownership of a 15 station dialysis facility

19 located in Manteno, Illinois. This facility is currently

20 controlled by Provena Health. Provena Health owns 50% of

21 Kankakee Valley Dialysis Network, LLC. The cost of the

22 project is \$1,178,300. This project was modified on

23 August 22, 2011. This was a Type B modification. The cost

24 of the project was increased from \$1,084,298 to \$1,178,300

1 an increase of \$94,002 or 8.67%. A public hearing was
2 conducted on September 16, 2011. Letters of support were
3 received and no letters of opposition were received. The
4 anticipated completion date is February 1, 2012.

5

6 #11-047 Resurrection Medical Center

7 Resurrection Health Care Corporation, Provena
8 Health, and Cana Lakes Health Care ("the applicants") are
9 requesting a change of ownership of a 360 bed acute care
10 hospital located in Chicago, Illinois. This facility is
11 currently controlled by Resurrection Health Care
12 Corporation. The cost of the project is \$550,729,657. A
13 public hearing was conducted on September 21, 2011.
14 Letters of support were received no letters of opposition.
15 The anticipated completion date is February 1, 2012.

16

17 #11-048 Saint Joseph Hospital

18 Resurrection Health Care Corporation, Provena
19 Health, and Cana Lakes Health Care ("the applicants") are
20 requesting a change of ownership of a 360 bed acute care
21 hospital located in Chicago, Illinois. This facility is
22 currently controlled by Resurrection Health Care
23 Corporation. The cost of the project is \$375,362,026. A
24 public hearing was conducted on September 21, 2011.

1 Letters of support were received no letters of opposition.

2 The anticipated completion date is February 1, 2012.

3

4 #11-049 Saint Francis Hospital

5 Resurrection Health Care Corporation, Provena

6 Health, and Cana Lakes Health Care ("the applicants") are

7 requesting a change of ownership of a 271 bed acute care

8 hospital located in Evanston, Illinois. This facility is

9 currently controlled by Resurrection Health Care

10 Corporation. A public hearing was conducted on August 23,

11 2011. Letters of support were received no letters of

12 opposition. The cost of the project is \$305,388,953. The

13 anticipated completion date is February 1, 2012.

14

15 #11-050 Saint Mary of Nazareth Hospital

16 Resurrection Health Care Corporation, Provena

17 Health, and Cana Lakes Health Care ("the applicants") are

18 requesting a change of ownership of a 387 bed acute care

19 hospital located in Chicago, Illinois. This facility is

20 currently controlled by Resurrection Health Care

21 Corporation. The cost of the project is \$297,655,283. A

22 public hearing was conducted on August 23, 2011. Letters

23 of support were received no letters of opposition. The

24 anticipated completion date is February 1, 2012.

1

2 #11-051 Provena St. Joseph Medical Center

3 Resurrection Health Care Corporation, Provena

4 Health, and Cana Lakes Health Care ("the applicants") are

5 requesting a change of ownership of a 480 bed acute care

6 hospital located in Joliet, Illinois. This facility is

7 currently controlled by Provena Health. The cost of the

8 project is \$622,383,667. A public hearing was conducted on

9 August 26, 2011. Letters of support were received no

10 letters of opposition. The anticipated completion date is

11 February 1, 2012.

12

13 #11-052 Holy Family Medical Center

14 Resurrection Health Care Corporation, Provena

15 Health, and Cana Lakes Health Care ("the applicants") are

16 requesting a change of ownership of a 188 long term acute

17 care hospital located in Des Plaines, Illinois. This

18 facility is currently controlled by Resurrection Health

19 Care Corporation. The cost of the project is \$166,499,169.

20 A public hearing was conducted on September 7, 2011.

21 Letters of support were received no letters of opposition.

22 The anticipated completion date is February 1, 2012.

23

24 #11-053 St. Elizabeth Hospital

1 Resurrection Health Care Corporation, Provena
2 Health, and Cana Lakes Health Care ("the applicants") are
3 requesting a change of ownership of a 108 bed acute care
4 hospital located in Chicago, Illinois. This facility is
5 currently controlled by Resurrection Health Care
6 Corporation. The cost of the project is \$51,828,180. A
7 public hearing was conducted on August 23, 2011. Letters
8 of support were received no letters of opposition. The
9 anticipated completion date is February 1, 2012.

10

11 (End of submission)

12

13 MR. GALASSIE: May I have a motion to approve
14 Project 11-039, 11-040, 11-041, 042, 043, 044, 045, 046, 7,
15 8, 49, 50, 51, 52, and 53, with a condition to include
16 local public health be invited to their local public -- to
17 local planning process and give feedback to the Board
18 approximately a year to eighteen months later, in case you
19 haven't gotten it within a year at their community
20 meetings. That motion having been made -- proposed -- let
21 me just stop, because I think Member Sewell had a question.

22 MR. SEWELL: No, I was just going to make the
23 motion.

24 CHAIRMAN GALASSIE: Oh. Motion made.

1 MR. EAKER: Second.

2 CHAIRMAN GALASSIE: Moved and seconded. Roll
3 call.

4 MR. DART: Motion made by Mr. Sewell, second
5 by Mr. Eaker.

6 Dr. Burden?

7 MR. BURDEN: Yes.

8 MR. DART: Mr. Eaker?

9 MR. EAKER: Yes.

10 MR. DART: Justice Greiman?

11 MR. GREIMAN: Yes.

12 MR. DART: Mr. Hayes?

13 MR. HAYES: Yes.

14 MR. DART: Mr. Hilgenbrink?

15 MR. HILGENBRINK: Yes.

16 MR. DART: Ms. Olson?

17 MS. OLSON: Yes.

18 MR. DART: Mr. Sewell?

19 MR. SEWELL: Yes.

20 MR. DART: Chairman Galassie?

21 CHAIRMAN GALASSIE: A resounding yes.

22 MR. DART: That's eight votes in the
23 affirmative.

24 CHAIRMAN GALASSIE: Congratulations.

1 (Applause)

2 CHAIRMAN GALASSIE: I'm going to recommend
3 that we take a ten-minute break, come back, and we'll be
4 going into some Board business. We're on break for --
5 until quarter to.

6 (Recess)

7

8 EXECUTIVE SESSION HELD

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10 MEETING RECESSED AT 3:48 P.M.

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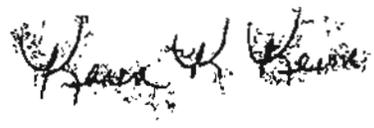
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CERTIFICATE OF REPORTER

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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