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

**OPEN SESSION
OCTOBER 13, 2011
DAY 2**

ORIGINAL

NATIONWIDE SCHEDULING

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761
217-782-3516

OPEN SESSION

DAY 2 -- OCTOBER 13, 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
14 Juan Morado - Assistant Counsel
15
16 Michael Constantino - IDPH Staff
17
18 Bill Dart - IDPH Staff
19
20 Claire Berman - IDPH Staff
21
22 David Carvalho - Deputy Director, IDPH
23
24 Michael C. Jones - IDFS

Reported by:

22 Karen K. Keim
23 CRR, RPR, CSR-IL, CRR-MO
24 Midwest Litigation Services
401 N. Michigan Avenue
Chicago, IL 60611

1 START TIME: 10:06 A.M.

2

3 CHAIRMAN GALASSIE: Good morning, ladies and
4 gentlemen. Welcome. The meeting is called to order -- or
5 reorder -- from our recess of yesterday, and we will be
6 starting with Item No. 11-038, Fresenius Medical Care of
7 Naperbrook. If representatives from there would please
8 come up to the front table, introduce yourselves, spell
9 your names for our Recorder, and we will have you sworn in.

10 While you're doing that, we will do roll call.
11 Bill, if you wouldn't mind.

12 MR. DART: Certainly.

13 Dr. Burden?

14 MR. BURDEN: Yes.

15 MR. DART: Mr. Eaker?

16 MR. EAKER: Here.

17 MR. DART: Justice Greiman?

18 MR. GREIMAN: Here.

19 MR. DART: Mr. Hayes?

20 MR. HAYES: Here.

21 MR. DART: Mr. Hilgenbrink?

22 MR. HILGENBRINK: Here.

23 MR. DART: Ms. Olson?

24 MS. OLSON: Here.

1 MR. DART: Mr. Penn?

2 (No response)

3 MR. DART: Mr. Sewell?

4 MR. SEWELL: Here.

5 MR. DART: Chairman Galassie?

6 CHAIRMAN GALASSIE: Here.

7 Thank you very much. If you folks would
8 introduce yourselves.

9 MS. RANALLI: Certainly. Good morning. Thank
10 you. My name is Clare Ranalli (spells name). To my left
11 is Lori Wright (spells name). To her left is Coleen
12 Muldoon (spells name), and to her left is Terri Gurchiek
13 (spells name).

14 CHAIRMAN GALASSIE: Michael, can we have a
15 State Agency Report, please?

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

17 The applicants are proposing the establishment
18 of a 16-station ESRD facility, located in approximately
19 10,000 gross square feet of leased space in Naperville,
20 Illinois. The cost of the project is approximately \$5
21 million.

22 The State Board Staff would like to note that
23 the applicants are requesting shell space as part of this
24 application, in the words of the applicants, to accommodate

1 additional growth, and have committed to coming back to the
2 Board for the additional stations. The anticipated project
3 completion date is December 31st, 2013. No public hearing
4 was requested, and no letters of support or opposition were
5 received by the State Board Staff.

6 Thank you, Mr. Chairman.

7 CHAIRMAN GALASSIE: Thank you.

8 And who will speak to the Board?

9 MS. RANALLI: Thank you. I'm going to turn
10 things over to Ms. Muldoon, but I did want to ask the Board
11 and hope that this would be appropriate, that similarly
12 with the applications yesterday, as Fresenius has five
13 applications up in a row, if some of the comments that we
14 make might be able to be addressed or flow to those
15 applications, and as we move on, we could address the
16 specifics. That would save time.

17 CHAIRMAN GALASSIE: Sure.

18 MS. MULDOON: My name is Coleen Muldoon. I'm
19 a regional Vice-President of Fresenius Medical Care, and I
20 just wanted to comment on a few things before we got
21 started.

22 First of all, I want to give a little history
23 of myself and how I work with the company. I have been in
24 dialysis for over thirty years. I was a Clinical Manager

1 for 10 years in one of our other facilities in Oak Park,
2 which borders the City. I've always been quality-driven,
3 and that has been my goal working with Fresenius. I worked
4 with a small company when I started out, and I was the
5 Clinical Manager, and now I'm working with Fresenius, which
6 acquired that company. The company I worked for was
7 quality -- completely driven by quality and as is
8 Fresenius. I would not be working for them today if I did
9 not believe that they were driven by quality. The
10 difference between working with a large company -- I did
11 hear that the quality might be compromised because it was a
12 large company. If anything, I've seen things completely
13 different. I feel the resources I have to do my job by
14 working with a large company are endless. If I ever have a
15 problem or concern, I know I can go to somebody and there
16 is a completely dedicated resource at my availability at
17 all times.

18 On the local level how we operate, considering
19 the size of our company, I'm the Regional Vice-President.
20 I have 45 facilities that I'm responsible for. I have 8
21 Area Managers who report to me and have responsibility for
22 those facilities under them, and monthly we have quality
23 meetings at all of our facilities, which our Medical
24 Directors are very active and take the lead role in those

1 discussions. We have Quality Regional Managers, who come
2 into our facilities a couple times a year to evaluate where
3 we are. We're highly regulated, dialysis highly regulated.
4 I don't think there is a dialysis company in existence
5 today who isn't all about quality. We would not be -- we
6 could not function if we didn't drive the quality in our
7 facilities.

8 The Area Managers meet with their Clinical
9 Managers on a monthly basis and also in their units two to
10 three times a month, just to make sure things are going
11 okay. When we identify problems in our facilities, we do
12 action plans, we put plans in place, and we do follow-up to
13 make sure that we adhere to those policies and everybody is
14 functioning at the same level in all of our facilities.

15 We all have problems in our facilities. We
16 address those immediately and work very closely with them
17 to turn that around. We have multiple resources at our
18 hand. Education, we have a huge Education Department, and
19 we train -- we put many weeks of training into our
20 employees, and we do ongoing education with our educators
21 coming into our facilities and working directly with our
22 facilities. So between our Quality Managers, the Area
23 Managers who audit, myself, the physicians who have
24 oversight, the Clinical Managers who have direct oversight

1 of the facility, there is many, many levels that take care
2 of what goes on in our facilities.

3 We are a large company, but that only provides
4 us the additional resources we need to function in a very
5 highly regulated, very competitive field of dialysis. So,
6 I feel very strongly about some of the comments that were
7 made about Fresenius, because as a nurse, I would not be
8 working for this company if I thought in any way our
9 quality was compromised by the size of our company, and I
10 do not believe that for a minute. I feel we have best
11 practice that we share with facilities.

12 We picked up a New Jersey algorithm from our
13 New Jersey people that completely turned around how we were
14 treating our patients and meeting the needs of our
15 patients, and that was because we shared best practice
16 between our facilities. We do that constantly.

17 Dr. Hakim is head of our company. He is
18 world-known and he drives quality. He drives it down to
19 the region. We are measured as Regional Vice-Presidents
20 against our quality. A leader board comes out, and we are
21 ranked by our quality, and Corporate will come in and
22 intervene if they don't think that we are functioning at
23 that level. So, there's a lot of oversights and a lot of
24 things in place, because of our size, to make sure that

1 those things are in place. So, when people say that a
2 smaller company can provide better care, I don't agree with
3 that at all. I think everybody wants to provide good care.
4 But as a large company, we are at a huge advantage,
5 state-of-the-art equipment, and our units are -- we are
6 always upgrading our units, our water systems. Our
7 machines are used by every dialysis company. Our
8 education, as I said, is beyond anyone's. We often have
9 our employees approached by other companies because they
10 know that we have the best Education Department in the
11 Chicagoland area.

12 So, I just wanted everyone to be aware of
13 that. I don't say much at these meetings. I come to a lot
14 of them. I support this. We talk much before we come in.
15 I feel we are very well prepared. I don't have to add
16 anything at the time, unless you ask questions that might
17 need to be added. But I think our projects are solid.
18 Every project I've ever heard in my region -- I have 45
19 clinics. My average utilization is 83 percent. So, the
20 units that we are building we are filling, and the reason
21 we fill those units is because of our affiliation with our
22 physicians, who have growing practices. They want to work
23 with us. They want to come in to our facilities, and
24 that's what drives our growth, is our relationship and our

1 strong relationship with our physicians.

2 So, I know we're big, but because of that --
3 and these physicians are in pockets. This isn't one, big
4 Fresenius family. These are practices that are set out
5 throughout Chicago, and then we partner with those, and as
6 they grow, we have to add stations or facilities to
7 accommodate that, and our size dictates that. So, I think
8 if we brought in every one of our physicians, you'd get
9 very positive comments. In fact, one of the other
10 applications that was opposed, there was many letters that
11 came in from our physicians. I don't know if you took the
12 time to read them or have the time to read them, because
13 the applications are pretty cumbersome. But they were
14 pretty extensive and they were very supportive of Fresenius
15 and what it offers them as a physician.

16 So, just wanted to share --

17 CHAIRMAN GALASSIE: We appreciate that, and
18 we appreciate your comments as well. To the application,
19 please.

20 MS. GURCHIEK: I just wanted to introduce
21 myself real quickly, as well. My name is Terri Gurchiek,
22 and I am an Area Manager in the Chicagoland area, and my
23 territory covers nine facilities. I am based out of a
24 facility, so I do interact with our patients every day. My

1 role is to support our nurses and our Clinical Managers
2 from an operation standpoint, making sure that they have
3 everything that they need to do their job, to continue to
4 take care of our patients.

5 I have worked as a nurse for years. I've been
6 doing this for 21 years. I was also Clinical Manager at
7 the Naperville facility for years, and actually that
8 facility was running with four shifts for almost two years
9 because of the high utilization, and that was very
10 difficult for our patients and for our staff to do that.

11 And I also just wanted to, real quickly,
12 mention, kind of saddling on what Coleen said, that I
13 know -- I'm not at all of these hearings --

14 CHAIRMAN GALASSIE: I'm sorry to interrupt,
15 but what is the relevance of you running four shifts? I
16 don't understand that part.

17 MS. GURCHIEK: I'm going to talk to the
18 quality. That does affect quality, running patients four
19 shifts a day. These patients aren't leaving until eleven,
20 11:30, twelve o'clock at night, and in terms of quality, we
21 do have -- and I am on our QA committee in every one of the
22 facilities that I cover. So, we do have to meet monthly,
23 and we go through every facility each month and go through
24 their quality indicators. The physicians are there, and

1 actually, all the physicians are invited and encouraged to
2 attend, and we go through every indicator for our patients,
3 and I know that over the past few months -- and even
4 yesterday -- there were physicians making statements they
5 were concerned about the quality. Those same physicians
6 admit patients to these clinics and have never once
7 attended one quality meeting regarding the patients, and
8 they do admit patients to all of the facilities that I
9 cover. The Medical Directors ultimately are responsible
10 for those patients. So, when those physicians don't come,
11 it is their responsibility to work towards setting up
12 action plans to improve the quality.

13 And I just wanted to point out that in that
14 market, my area, which is all I can speak to, they are
15 providing exceptional quality in some of these facilities.
16 Bolingbrook and Naperville have even received awards from
17 the Renal Network because of the quality achievement that
18 they have had. So, I just wanted to mention that, because
19 it's very disheartening to hear that there were statements
20 made by these physicians in these facilities about the poor
21 quality, because it certainly is not, not true.

22 CHAIRMAN GALASSIE: The Board is -- hears
23 your message, and we understand your message. And
24 understand, we have very little control over what people

1 say. But the more we hear, it filters, I think, within a
2 reasonable amount, what people say. We are not interested
3 in having A talk about B. That's counter-productive for
4 everyone in this room. So thank you.

5 MS. RANALLI: Thank you, Chairman Galassie.
6 And Ms. Wright is going to speak to the specifics of the
7 application. But one thing you asked was about the
8 Naperville clinic running four shifts. Part of the reason
9 for the Naperbrook proposed facility in front of you is
10 because of over utilization in Naperville, which was
11 running four shifts, which is not a positive or optimal way
12 to run a clinic, because of its high utilization. So, that
13 Naperville clinic's utilization is relevant to this
14 Naperbrook facility.

15 CHAIRMAN GALASSIE: So, is the point that if
16 Naperbrook is approved, Naperville will no longer run four
17 shifts.

18 MS. WRIGHT: They are not currently. They're
19 at 89 percent utilization. Once they hit 100 percent and
20 go over, then we do have to add a fourth shift.

21 I'm just going to talk to you about the
22 project itself.

23 CHAIRMAN GALASSIE: Please do.

24 MS. WRIGHT: The City of Naperville -- I'm

1 sure some of you are familiar with it -- lies in DuPage
2 County. However, there is a very small portion of it that
3 lies over the border into Will County and is actually where
4 we are putting the facility. So, it is serving Naperville,
5 but it's in Will County. The project is going -- it is on
6 the border. It is going to serve HSA 7 and 9 almost
7 equally. If you have the application in front of you on
8 your computers, there's a map on page 48 that shows where
9 the facility is located in relationship to the two counties
10 and the two HSA's. Given this, we think that while we are
11 aware there is no need currently in HSA 9 or 7, that -- I
12 know the new inventory is going to be coming out
13 shortly -- we expect that there will be a need. We think
14 the combined need should be considered on this project.

15 The proposed Naperbrook facility is going to
16 serve a two-fold purpose. The first one is to meet current
17 need. As we have just said, the Naperville facilities are
18 both -- we have two of them there, at Naperville and
19 Naperville North -- are both pushing 90 percent
20 utilization, 88.89 and 86.90. And, like we said before,
21 once a facility reaches 100 percent, then we do have to add
22 a fourth shift, which is really hard on the patients,
23 because they are dialyzing until midnight, and they're
24 elderly, they're ill, and this is just really hard on them.

1 CHAIRMAN GALASSIE: You have to add that one
2 shift because there's no other options?

3 MS. WRIGHT: Yeah. Otherwise they would have
4 to drive out of their area for dialysis.

5 CHAIRMAN GALASSIE: Thank you.

6 MS. WRIGHT: The Bolingbrook facility is
7 essentially at 80 percent. It's 79.86, and we -- as far as
8 Naperville and Bolingbrook, we have already expanded all of
9 our facilities there as far as we can expand them at this
10 time. There is no more room. So, we're really out of
11 places to put these patients who are going to be pushing
12 towards 100 percent probably in the next year, and we are
13 going to need places for these patients to go.

14 If you look at the table, Table Five on page
15 12 of the State Agency Report, you will see that the
16 overall utilization of the facilities within 30 minutes is
17 at 77 percent, and as of yesterday, there were two projects
18 approved, the Oak Brook project -- the overall utilization
19 of those facilities was 78 percent -- and the Bolingbrook
20 project, and the overall utilization of those facilities
21 was at 76 percent. If you look further, the facilities
22 within 25 minutes travel are at a average of 86 percent
23 utilization. This shows that the high utilization is
24 closer to the Naperville, Bolingbrook area. It's not in

1 the outlying areas. The only facilities on the list that
2 really have any excess capacity are the Fresenius Lombard
3 facility and Sun Health in Joliet. These facilities are
4 near 30 minutes away, and they do not serve the residents
5 of Naperville.

6 It's in the best interests, as we have talked
7 about this, and many other providers have to have a
8 facility close to the patient's home, because
9 transportation is a hardship for these patients. As well,
10 on page 46 of the application, there's a chart.
11 Bolingbrook, Downers Grove, Naperville, Plainfield,
12 facilities that Nephrology Associates admit to, have seen
13 an average of 10 percent growth in their practice at these
14 facilities in the past five years. If you look at this
15 rate and apply it to future, the Naperbrook facility -- the
16 area facility -- the utilization of area facilities is
17 going to be at 122 percent in a little over two years, if
18 the Naperbrook facility is not approved.

19 The second purpose for this project is
20 planning for the future. Our current Naperville facility
21 is on the campus of Edward Hospital. It's in leased space.
22 Our lease is going to be up in a little over two and a half
23 years, in 2014. At that time, we are going to have to
24 vacate the premises there. Those patients will need a

1 place to go. The Naperville facility has 2,000 gross
2 square feet of unfinished, shell space that's going to be
3 ready to cost-effectively, quickly be built into
4 dialysis -- availability to put extra stations in there.
5 So, what we hope to do at that time is relocate the
6 patients in the dialysis stations from Naperville to the
7 Naperville site. It's already there. This will be more
8 cost effective. We're going to lock into the current lease
9 price, and, also, we're not going to have to pay real
10 estate brokers to go out and find us another building.

11 The other advantage to this is this is just an
12 ideal site and has easy access, ample parking. There's
13 room there for expansion. Much of the property that we
14 have looked at in the last several months, either there was
15 an existing site, it was too small, there wasn't ample
16 parking, it was on the second floor of a building, which is
17 not good for dialysis, because we use a lot of water. And
18 any vacant land that we found that we thought would be a
19 good site, also we found that we could not get medical
20 zoning for it.

21 So, we found an ideal site. We would like to
22 have it for the current need and also the future need for
23 our Naperville facility. Thank you.

24 CHAIRMAN GALASSIE: Thank you. We appreciate

1 that.

2 MS. RANALLI: We just open up questions to the
3 Board at this point.

4 CHAIRMAN GALASSIE: Questions from Board
5 members?

6 MR. GREIMAN: I have a question, Mr. Chairman.

7 CHAIRMAN GALASSIE: Yes, Judge.

8 MR. GREIMAN: This is a little different. You
9 have a lot of projects, and I notice that you say, for
10 example, this project, that you have cash and securities of
11 a million eight. The next project you have cash securities
12 of a million three. So -- and you have a million something
13 on all of the projects. So, the question I have is what do
14 you do internally? Do you separate those funds and say
15 this goes to the Naperville one and this goes to such and
16 such, or are we just talking about your bank account?

17 MS. RANALLI: I believe that the cash and
18 securities that are reported for each application depends
19 upon the timing, when the application is submitted, and as
20 you said, it ebbs and flows. So, it just reflects the time
21 the information is provided by the Treasurer, what that
22 figure would be.

23 MR. GREIMAN: So, we don't have security set
24 aside then? We just have a bank account of the company?

1 MS. RANALLI: That's right. They're not
2 security set aside for each project. However, each project
3 has a cost associated with it. Almost -- most of the
4 project costs relate to the lease for the space, and that,
5 of course, is segregated cash that is dedicated to pay for
6 those leases for the project separately.

7 CHAIRMAN GALASSIE: Other questions?
8 Dr. Burden?

9 MR. BURDEN: I apologize once again for
10 returning to something I read yesterday. I listened to
11 what I thought was Knute Rockne at halftime when they were
12 losing in the first half. I don't want you to take this
13 personally, but perhaps you will.

14 I am aware that we made statements yesterday,
15 and I look forward to a retreat where we can resolve some
16 of the issues that I continue to have. You represent one
17 of the two corporate chains that have been consistently
18 profitable, together making \$2 billion in operating profits
19 a year. I am hung up on that. When I listen to your
20 accolades about how well you're taking care of patients, I
21 won't go into this, but there are many opinions that would
22 challenge that. I don't want to make another speech about
23 this, but I think we're going to have to address it.

24 I really feel that I would -- leaning more

1 comfortably towards recognizing the fact that you, as a
2 company, are doing so well, if I heard some interesting
3 comments regarding maybe making contributions, economic
4 contributions to the areas that you're caring for -- I'm
5 not looking at charity care per se, but I'm looking at a
6 thought that might influence some of the negatives that I
7 read regarding the whole operation that you represent and
8 claim to be so ethical about. I worked for 40 years in
9 this community. I worked with several dialysis units, and
10 I'm well aware of what's going on, so I don't need to be
11 told by somebody who represents the company about how great
12 they are, about how ethical they are and how honest you are
13 and giving such wonderful care, when I recognize -- and
14 I'll read from this.

15 "As the United States moves to expand access
16 to healthcare, dialysis offers potent lessons." And this
17 is the big picture I'm looking at. "Its story expresses
18 the fears of both ends of the ideological spectrum about
19 what can happen when the doors to care are thrown wide
20 open. Neither government controls nor market forces have
21 kept costs from ballooning or ensured highest-quality
22 care," which you dispute, of course. "Almost every key
23 assumption about how the program would unfold has proved
24 wrong." When we have our little get-together, I will fully

1 expect and listen to what you just said repeated, so you
2 can challenge this stuff. But this is well documented,
3 with a bibliography of two pages. I'm a little upset to be
4 lectured to when I know damn right well that some of what
5 you said is very self-serving.

6 Let me hear more about how interested you are
7 in making sure that the poorer communities -- this whole
8 system -- I'll read this. "One reason this system's
9 problems have evolved out of the health care spotlight is
10 that kidney failure disproportionately affects minorities
11 and the dispossessed. But given a patient pool growing by
12 3 percent a year and the outside 6 percent bite that the
13 kidney program takes from the Medicare budget, we ignore
14 dialysis at our own risk. More and more leaders in the
15 field, he said, are starting to say this isn't sufficient."

16 We really -- I have some problems with the
17 whole area, and I hope to resolve them to the benefit of
18 you. The patients primarily. Look forward to hearing more
19 about what you might do for these people that you seem to
20 be caring so diligently for and you claim to be doing such
21 a marvelous job. I hope that's true. That's what I'm
22 saying. I would like to see more evidence from it, and I
23 would be impressed if somebody from your company would step
24 forward and say, "We're going to make a contribution

1 economically to these poor people, poor communities that
2 are looking in a bad climate." We've got a horrible
3 economy going on right now, and we're reading about all the
4 amount of money that goes to this area, and I don't know of
5 any dialysis unit right now in the City that's suffering
6 economically, although I do know how well you're doing in
7 terms of care and treatment.

8 That's enough of my speech. It has nothing to
9 do with how I look at your application. I try to be honest
10 and open, but I could not listen to what you said and not
11 feel we've got to come back with something. My opinion is
12 my opinion, not the rest of the Board. They vote for
13 themselves. But I'd like to hear some of what I said, look
14 forward to hearing -- let's put it that way -- and maybe
15 when we have our retreat, which we're planning on in 90
16 days, you'll step forward and prove me wrong.

17 CHAIRMAN GALASSIE: I'd like to continue with
18 more questions rather than a response.

19 MS. OLSON: I have a question. If I'm doing
20 my math right, we're now -- HSA 7, plus 18 stations, and
21 HSA 9, plus 68?

22 MR. CONSTANTINO: Excess of 68, yes. I have
23 to point out that your rules require us to look at the
24 station need in the planning area where the facility is

1 located.

2 MS. OLSON: And this one is physically

3 located --

4 MR. CONSTANTINO: Physically located in HSA 9,

5 yes.

6 MS. OLSON: Thank you.

7 CHAIRMAN GALASSIE: Member Sewell?

8 MR. SEWELL: I have a question, just for my
9 own education. I don't know whether it's for you or for
10 the Staff. But I'm on page 12 of the Staff Report, and I
11 see a couple of quality measures, and I guess I want to
12 understand what those are. Something called URR. What is
13 URR?

14 MS. MULDOON: It's the Urea Reduction Rate,
15 and we test the patients. It shows from when they start
16 dialysis to the end, when they end the dialysis, that
17 actual treatment, the clearances, how well do we clean
18 their blood. So, that measures that.

19 MR. SEWELL: And the benchmark should be equal
20 to or greater than 65 percent?

21 MS. MULDOON: Correct.

22 MR. SEWELL: And the other is Kt/V. What is
23 that?

24 MS. MULDOON: It's another way of measuring

1 the adequacy of dialysis. URR just measures that snapshot,
2 and then the Kt/V measures the -- it's the actual dialysis,
3 just two different ways of measuring adequacy of dialysis.

4 CHAIRMAN GALASSIE: I have a question, and I
5 promise, Miss Ranalli, I'll let you speak to the issue. I
6 don't pretend to fully understand your business model,
7 though I think I'm learning more and more about it. But I
8 think there tends to be agreement that fourth shift service
9 is less desirable by everyone. When you close Naperville
10 and you move to Naperbrook, is there a possibility that
11 expansion could occur to absorb that population without
12 having to automatically go to a fourth shift?

13 MS. RANALLI: Yes. That's the anticipated
14 plan.

15 CHAIRMAN GALASSIE: Would you accept that as
16 a contingency of approving this, based upon that?

17 MS. RANALLI: Yes, absolutely.

18 MR. URSO: Not to have a fourth shift.

19 MS. RANALLI: No, we would not run a fourth
20 shift. When Edward -- we've been working with Edward, but
21 they want that space back. As we work that out, we would
22 not start a fourth shift at the Naperbrook facility.

23 CHAIRMAN GALASSIE: Okay. I heard that.

24 MS. OLSON: So, Chairman Galassie, you're

1 suggesting that they would be closing stations in order to
2 make up these stations they're opening?

3 CHAIRMAN GALASSIE: I'm not sure I understand
4 your question, but I'm suggesting that would they agree to
5 once Naperville is closed and that population is moved to
6 Naperbrook, that Naperbrook would either absorb it without
7 a fourth shift or they would expand it so they wouldn't
8 have to establish a fourth shift.

9 MS. RANALLI: Yes.

10 CHAIRMAN GALASSIE: Again, the point being,
11 we all want to try to avoid a fourth shift, if at all
12 possible.

13 Ms. Ranalli, you had a comment.

14 MS. RANALLI: I'll be as brief as possible,
15 but I do feel, just for the record, we need to respond to a
16 couple of things.

17 The quality -- I'm glad you brought up the
18 quality matrix that are in the application and that are
19 part of the Board's review criteria. Fresenius has for 15
20 years I've been working with them always met this Board's
21 matrix. Also, with respect to the quality issues that were
22 raised by the ProPublica article, et cetera, I think those
23 are all important things for everyone to talk about, but
24 one thing I think is important -- at least to me, maybe

1 just because I'm a lawyer -- is sort of looking at things
2 from an evidentiary standpoint.

3 Fresenius facilities have served the residents
4 and the patients in the state of Illinois for at least over
5 15 years, and if you go down to southern Illinois, where
6 the BMA facilities are, possibly 20 to 30 years. They have
7 never had any quality issues at all with the Illinois
8 Department of Public Health or otherwise. When they are
9 surveyed, if there are deficiencies, they are never being
10 what, level A or 3, the high-level deficiencies where there
11 are significant issues. They are all minor issues.

12 I work with Fresenius on some of those
13 regulatory issues as well. They immediately address those,
14 and again, they've always been minor level deficiencies.
15 So, there's a history of our partnering with the State of
16 Illinois and providing good quality.

17 And then on the charity or community benefit
18 point, Fresenius has clinics throughout many neighborhoods
19 in metropolitan Chicago and outside of it that are
20 economically-challenged, probably more than any other
21 provider, because it's largest, but also because it does go
22 to those communities, and I think you bring up a very good
23 point. As a for-profit entity -- and, also, any entity
24 that provides dialysis struggles with charity care, as you

1 define it. Community benefit is important, and I think
2 there are things we can do and are committed to do, and
3 maybe even firmly commit, as we move further and dialogue
4 with this Board, particularly in those communities like
5 Humboldt Park, South Loop, where there are issues that we
6 might be able to address regarding diabetes care,
7 prevention, some of the underlying problems that cause
8 end-stage renal disease, so those patients don't even
9 arrive at our facility requiring dialysis.

10 And, lastly, I received approval from a friend
11 of mine who has private insurance. So, a patient that is
12 extensively in need of a dialysis clinic, would want to
13 keep dialyzing there. She is my age, so a very young lady.

14 (Laughter)

15 MS. RANALLI: She has had three transplants.
16 She dialyzes at Fresenius. She has lupus. She has had
17 three transplants. She said they worked with her. After
18 the first two, it was a challenge for her to get a third,
19 but she finally was able to get a family member as a donor,
20 because she rejected the first two kidneys, and it
21 really -- it's heartening to hear that story, since I don't
22 hear from the patients' perspective. But that's what she
23 told me, and she was very pro-Fresenius and, again, a
24 private insurance patient and yet was very much encouraged

1 to get her current transplant, which she's had in place for
2 a year and is doing very well.

3 MR. HAYES: Mr. Chairman, I have some
4 questions.

5 Mike, can you go over -- you mentioned earlier
6 yesterday that you would update the Board exactly for
7 these -- the amount of stations that -- when we approved,
8 that you would update the need or the excess for the
9 different areas, and I think you just did that with Kathy
10 Olson's, Member Olson's question there. So, could you go
11 over that again?

12 MR. CONSTANTINO: Yeah. HSA 9, the planning
13 area in which your rules require us to review this project,
14 has an excess of 68 stations.

15 MR. HAYES: Okay.

16 MR. CONSTANTINO: HSA 7, by my count they have
17 an excess of 21 stations.

18 MR. HAYES: Okay. The other question that
19 came up at the last meeting from Member Penn, I think, even
20 the Judge as well, concerning revenue per facility in the
21 state of Illinois, and did you provide that information?

22 MS. RANALLI: No, we have not. We've been
23 talking with Mr. Constantino about providing that
24 information and how it -- what exactly you're looking at,

1 net revenue by clinic, et cetera, and we had hoped that we
2 might have the meeting that has been discussed sooner, but
3 apparently, that's been delayed, and we wanted to talk
4 about that then and figure out exactly what it was you were
5 looking for. We also have concern -- well, maybe. It
6 depends exactly what the information is you want. But we
7 have concerns about the proprietary nature of the
8 information, and right now, if we were certain what you
9 wanted, we could provide it, if it would be maintained in a
10 confidential way, but we don't know that your process
11 allows for that. And so, I think, we don't want to
12 prohibit you from having that information and we're not
13 objecting necessarily to providing it. We want to figure
14 out more what that is, what you're looking for and how we
15 can provide it to you, and, depending on what you're
16 looking for, whether it is proprietary. So, the net
17 revenue I know for hospitals. I think you asked for that
18 information, also --

19 CHAIRMAN GALASSIE: Right.

20 MS. RANALLI: -- in the application, and
21 hospitals file a form with the State, providing net revenue
22 by facilities, providing the net revenue by clinics.
23 Depending on what you're looking for, again, could reveal,
24 again, proprietary information to our competitors, to

1 payors, et cetera, and that's the concern. Plus, we're not
2 even sure exactly what you're looking for. So, we had
3 hoped to dialogue with you about that, if that's allowed by
4 you.

5 CHAIRMAN GALASSIE: I don't -- if you're
6 suggesting the retreat that we're planning to have on this
7 issue, I don't believe that's the place for this dialogue.

8 MS. RANALLI: Okay. Well, then any
9 appropriate --

10 CHAIRMAN GALASSIE: If there is confusion for
11 what it is we're requesting, then I think we better
12 articulate that. If someone can articulate that -- I don't
13 think I can.

14 MR. EAKER: I can speak to part of it. I've
15 been concerned that with every Fresenius application, you
16 use the same safety net information, which is a national
17 thing for three years. Is that correct? I'm looking at
18 2008, 2009, 2010 charity care. It's the information on
19 Table Four. I had asked for information regarding charity
20 care on a local level. What -- is it an across-the-board
21 thing? The response, if I remember right, from the past
22 was that "Well, no one ever gets turned away." But that
23 really doesn't answer the concern that I have. Most of the
24 time you relate self-pay as charity care, and I don't quite

1 understand that, because there could possibly be some very
2 wealthy self-pay people who doesn't need charity care. So,
3 I was looking for information that would break down those
4 categories.

5 MS. RANALLI: We have -- and thank you.
6 That's helpful, and we have changed the way we provide the
7 data in response to the question for net revenue by clinic.
8 Self-pay patients are patients that -- it's uncompensated
9 care. So, what we've done to try and provide more specific
10 information to the Board is we've provided the number of
11 uncompensated treatments that we -- each clinic and each
12 facility, and this is for Illinois, by the way. We provide
13 the number of Medicaid treatments that are provided at all
14 of the various clinics. So, that -- and, of course, the
15 Medicare percentage of treatment. So, that's the
16 information, how we're breaking it down now. The
17 uncompensated treatments are treatments, again, that we
18 just are not paid for, and that, honestly, doesn't occur
19 that frequently, because most patients are entitled to
20 obtain coverage which goes back to what was being discussed
21 yesterday about this being sort of a socialized medicine
22 experience, which was -- happened a long time ago, to make
23 sure patients weren't dying who shouldn't be dying because
24 they couldn't afford treatment or treatment wasn't

1 available. That's why the community benefit issue -- not
2 to change the subject, because we want to give you the
3 information you want on the uncompensated care and the
4 charity care, but I'd like to see a dialogue with the
5 dialysis industry that also addresses its ability to
6 provide community benefit, since charity care and the way
7 you think about it for a not-for-profit hospital that might
8 actually provide free care, promote free care, advertise
9 free care, provide free care is a little bit different. We
10 can't do that because of Medicare rules, et cetera, because
11 we are a for-profit company.

12 MR. HAYES: Mr. Chairman?

13 CHAIRMAN GALASSIE: Yes, Mr. Hayes.

14 MR. HAYES: The revenue by clinic, is that
15 readily available information?

16 MS. RANALLI: No.

17 MR. HAYES: Could that be -- from publicly
18 available information from the financial statements, you
19 have revenue per clinic or revenue per day, per -- revenue
20 per treatment, as well as the number of treatments at the
21 facility, and could that be calculated that way?

22 MS. RANALLI: Revenue per treatment, like
23 broken down by Medicaid and uncompensated care? Is that
24 what you're asking?

1 MR. HAYES: Well, let's start out with the
2 gross number here, because that was a concern, and the
3 revenue by clinic. Is the revenue per treatment and then
4 the number of treatments at a facility -- and that would
5 calculate pretty close to revenue, even though this is all
6 over the United States.

7 MS. RANALLI: That's what we're doing now.
8 And, also, the numbers in our application are Illinois.
9 Those are not national numbers. That is the state of
10 Illinois. And we're doing that now, very recently. In
11 response to the dialogue I've had with Mr. Constantino on
12 this issue, we have broken down those numbers. The
13 applications before you today may not have that, because
14 they were filed a couple of months ago, but the
15 applications filed very recently do have what you're
16 requesting.

17 MR. HAYES: But they don't have revenue by
18 clinic, a total revenue by clinic.

19 MS. RANALLI: A total number, like the
20 Naperville clinic's net revenue is X?

21 MR. HAYES: What kind of revenue per year does
22 Naperville generate?

23 MS. RANALLI: No, I don't believe the
24 applications include that. Instead, for, say, the

1 Naperville clinic, they would break down the revenue by
2 uncompensated treatment, Medicaid treatment, et cetera, but
3 the net revenue number is not there, other than for the
4 entire state of Illinois.

5 CHAIRMAN GALASSIE: Let me make a -- I'm
6 sorry, John.

7 MR. HAYES: You know, I think we'd like to see
8 that. If you were able to do it by the different
9 categories here and your Medicare and Medicaid and self-pay
10 and then charity care, you then would be able to come up
11 pretty close to your total revenue for a clinic. Do you
12 have to do that for CMS and other reporting to other
13 government agencies?

14 MS. RANALLI: No.

15 MR. HAYES: Do you have to do that for the
16 Illinois Department of Public Health and Medicaid?

17 MS. RANALLI: No.

18 MR. HAYES: Okay. Well, could that be done by
19 publicly-available information? It would take -- I don't
20 think it would take too long, an Excel spreadsheet with
21 that.

22 MS. RANALLI: I think we could. Hearing what
23 you're saying, I think we could look into that and maybe
24 present something to Mike that he could then share with the

1 Board and see if it's what you're looking for. I mean,
2 that would at least get us beyond the current place where
3 we are in dialogue.

4 CHAIRMAN GALASSIE: John, can I ask you a
5 question? Rather than trying to, perhaps, ask them for
6 every facility in Illinois -- and I think they get the gist
7 of what we're asking for -- I think it would be better for
8 them to voluntarily supply it than we making it a
9 contingency. Could we start with a sample and give us a
10 sample of facilities from the four quadrants of the state,
11 maybe -- how many facilities do you have in the state?

12 MS. RANALLI: I think close to 100.

13 CHAIRMAN GALASSIE: By the HSA or something
14 like that, as opposed to all 100, initially, and if that
15 doesn't satisfy where you're coming from, please say so.
16 That's just a thought.

17 MR. HAYES: Well, I would agree with starting
18 out with a sample. I wouldn't have any problem with that.

19 CHAIRMAN GALASSIE: Let them send that to
20 Mike.

21 MR. HAYES: And then we could start from
22 there, and I think that would answer some of the Board
23 member's questions associated with this issue.

24 CHAIRMAN GALASSIE: We respect the

1 proprietary aspect of it. We'd like to have information
2 for our knowledge of how the system is working. And,
3 again, perhaps my ignorance, but the only charity care must
4 be non-Medicare and non-Medicaid person who walks in the
5 door, right, because everybody else is covered.

6 MS. MULDOON: Right. As we said, we still get
7 -- we take undocumented patients also, but they also can
8 get coverage in the state of Illinois. So there really
9 isn't anybody in -- I mean, in our other states we do a lot
10 of charity care, but in the state of Illinois, usually we
11 have coverage. It's very rarely that we can't get a
12 patient covered.

13 CHAIRMAN GALASSIE: If we're coming to a
14 consensus -- unless Dr. Burden's issue is to this, if we're
15 coming to a consensus, then rather than a contingency on
16 this, we would be asking for you in the spirit of this
17 dialogue to give us a sampling of whatever the number --
18 how many HSA's are there, eight, eleven?

19 MR. CONSTANTINO: Eleven.

20 CHAIRMAN GALASSIE: So, if you give us one in
21 each, that's ten percent.

22 MR. BURDEN: I want to read something briefly
23 that addresses this. "ProPublica first asked CMS for
24 clinic-specific outcome data it collects, at taxpayer

1 expense, two years ago under the Freedom of Information
2 Act. The agency" -- that's CMS -- "declined to say whether
3 it would release the material until last week, as this
4 story neared publication. It subsequently has provided
5 reports for all clinics" -- all U.S -- "from 2002 to 2010.
6 ProPublica is reviewing this data and plans to make it
7 available for patients, researchers and the general
8 public."

9 I think that answers your question.

10 MS. RANALLI: That's quality data, not
11 financial.

12 MR. BURDEN: That's right.

13 MS. RANALLI: When you asked the question, I
14 was responding to financial.

15 MS. MULDOON: I think it would be good, when
16 we do do this, we put the number of facilities that are
17 treated in that HSA, because you're going to see that the
18 majority of our patients are in inner city facilities, in
19 HSA's with reduced revenue.

20 MR. SEWELL: I don't know who I want to ask
21 this, but revenue per facility -- don't you file Medicare
22 cost reports?

23 MS. MULDOON: Yes.

24 MR. SEWELL: It's got to be in there.

1 MS. MULDOON: It is.

2 MR. SEWELL: Okay.

3 CHAIRMAN GALASSIE: So, if you're filing it
4 with Medicare, what's the hesitation in filing it with this
5 Board? We just spent 20 minutes talking about whether to
6 put a contingency on this and that the Board wants this
7 information. If they're giving it to Medicare, they should
8 be giving it to us.

9 MS. RANALLI: The cost reports, I believe, are
10 public. So, why don't we then provide cost reports, as you
11 suggested -- well, we'll break it down in an Excel
12 spreadsheet and, we could provide a cost report for a
13 sampling of clinics, and, hopefully, if that answers your
14 question, then -- and that is the data you're looking
15 for --

16 CHAIRMAN GALASSIE: That's acceptable, but,
17 again, because we've had this dialogue, if you're
18 submitting it on all clinics to Medicare, what's the point?
19 Why aren't we submitting it? Then we want to see all
20 hundred. Yeah, of course, it's public information. Why is
21 there reluctance to give public information to a public
22 body?

23 MS. RANALLI: We have to see what information
24 is on the cost report. I'm not sure it's exactly what

1 Mr. Penn and Mr. Hayes and others have asked for.

2 MS. MULDOON: We'll pull the cost reports.

3 MS. RANALLI: Absolutely. But we've been
4 told -- that's the reason -- back in my mind, I'm concerned
5 that it may not be exactly what you're looking for, but
6 that's a good start.

7 CHAIRMAN GALASSIE: That's right. Appreciate
8 it, Ms. Ranalli. It would be a good start.

9 Now, Members, it's your decision. I'm going
10 to be making a motion here. If you want a contingency on
11 this motion, you have every right to. I will be making
12 a -- recommending a contingency on this motion that when --
13 if approved, when the Naperville facility closes and moves
14 to Naperbrook, that there will not be a fourth shift opened
15 in order to accomplish that.

16 MR. SEWELL: May I ask a question?

17 CHAIRMAN GALASSIE: Yes, sir.

18 MR. SEWELL: Okay. I'm confused by your
19 references to Naperbrook. That's the -- isn't that a
20 corporate name? That's a place too?

21 CHAIRMAN GALASSIE: Yeah.

22 MR. SEWELL: There's a place in the world
23 called Naperbrook? I shouldn't say "world".

24 MS. MULDOON: Actually, it's the name of the

1 dialysis facility.

2 MR. SEWELL: But it's not a geopolitical unit.

3 CHAIRMAN GALASSIE: No.

4 MR. SEWELL: When you say move to that --

5 MS. WRIGHT: The site is halfway between
6 Naperville and Bolingbrook, thus Naperbrook.

7 MR. URSO: Mr. Sewell, the application is
8 titled "Naperbrook," but they list the city as Naperville,
9 but I guess it's actually Bolingbrook.

10 MS. WRIGHT: It's actually in Naperville, but
11 it lies in Will County. It's kind of confusing.

12 CHAIRMAN GALASSIE: I'm going to recommend a
13 motion. Do we have a motion to approve Project 11-038 for
14 the establishment of a 12-stage ESRD facility in
15 Naperville, Illinois, with the condition that when the
16 Naperville facility closes and that population shifted to
17 Naperbrook, the Naperbrook facility, that a fourth shift
18 will not be added to accommodate, and that a report would
19 come back to the Board a year later.

20 MS. RANALLI: To confirm that fact, yes.

21 MS. WRIGHT: We will be filing a CON
22 application at that point to discontinue the Naperville
23 facility.

24 MR. URSO: Do you have an anticipated date

1 when you are going to do that?

2 MS. WRIGHT: Probably in mid to the end of
3 2013.

4 CHAIRMAN GALASSIE: We have a lengthy motion
5 on the floor. If it's working, I'll ask for a motion and a
6 second. Let me just get a motion and a second.

7 MR. BURDEN: So moved.

8 MR. HILGENBRINK: Seconded.

9 CHAIRMAN GALASSIE: Moved and seconded. Thank
10 you very much.

11 Comment, Mr. Carvalho?

12 MR. CARVALHO: The apparent life cycle of
13 these facilities is that they open up, they're
14 underutilized, utilization builds, and then it ultimately
15 goes to a situation where they go to a fourth shift and
16 then they seek an additional. So, was your motion
17 intending to never allow the facility to go to a fourth
18 shift, or just stop the fourth shift until some future time
19 when the demand changes?

20 CHAIRMAN GALASSIE: My motion was to
21 eliminate the fourth shift.

22 MR. CARVALHO: Forever?

23 CHAIRMAN GALASSIE: Correct.

24 MS. RANALLI: Right, because within one year,

1 we probably wouldn't even be admitting patients yet. So, I
2 understood it to never operate a fourth shift.

3 CHAIRMAN GALASSIE: Right. We have a motion
4 and a second. Roll call, please.

5 MR. SEWELL: Excuse me, Mr. Chairman, but the
6 motion is to approve with that condition?

7 CHAIRMAN GALASSIE: Correct.

8 MR. SEWELL: Okay. I never heard "approve".

9 CHAIRMAN GALASSIE: Okay. Motion to approve.

10 MR. DART: Motion made by Dr. Burden, seconded
11 by Mr. Hilgenbrink.

12 Dr. Burden?

13 MR. BURDEN: Did I understand, Mike, that you
14 said the number of beds excess in HSA 9, subsequent to the
15 approval of yesterday's Bolingbrook dialysis, is now what?

16 MR. CONSTANTINO: 68.

17 MR. BURDEN: 68?

18 MR. CONSTANTINO: Yes, sir.

19 MR. BURDEN: I vote no.

20 CHAIRMAN GALASSIE: Mr. Eaker?

21 MR. EAKER: I'm going to abstain.

22 MR. DART: Justice Greiman?

23 MR. GREIMAN: Aye.

24 MR. DART: Mr. Hayes?

1 MR. HAYES: Well, because of the excess beds
2 in the HSA 9 of 68 and the excess beds in HSA 7 of 18 now,
3 I'm going to vote no.

4 MR. DART: Mr. Hilgenbrink?

5 MR. HILGENBRINK: Yes.

6 MR. DART: Ms. Olson?

7 MS. OLSON: No, for the same reasons just
8 stated.

9 MR. DART: Mr. Sewell?

10 MR. SEWELL: No, due to excess capacity.

11 MR. DART: Chairman Galassie?

12 CHAIRMAN GALASSIE: The Chair intended to
13 vote no on this subject until the dialogue took place this
14 morning and a commitment to avoid a fourth shift. The
15 chair votes yes.

16 MR. DART: That's three votes yes and four no.

17 CHAIRMAN GALASSIE: Motion does not pass.

18 MR. DART: And one abstention.

19 MR. URSO: You'll have another opportunity to
20 come before the Board and also submit additional
21 information, if you so desire.

22 CHAIRMAN GALASSIE: And you folks are going
23 to remain for our following items. Thank you very much.
24 Significant dialogue, as we have four more applications

1 here from Fresenius.

2 Moving on to Item 11-057 -- I'm sorry --
3 11-054. Those of you who have not introduced yourselves,
4 please do so, and then we will swear you.

5 MS. NORA: Dr. Nancy Nora (spells name).

6 MR. BRANDENBURG: Brian Brandenburg (spells
7 name).

8 MS. PATEL: Dr. Shalani Patel (spells name).

9 CHAIRMAN GALASSIE: Prior to your testimony,
10 we're going to bring up public comment.

11 MS. AVERY: Our first person in opposition of
12 Project No. 11-054 is Dr. Tammy Ho. Following Dr. Ho is
13 Richard Berkowitz. Following Richard is Joseph Reinholtz.

14 CHAIRMAN GALASSIE: Okay. We have Ms. Ho
15 first.

16 MS. HO: Hi. Good morning. My name is
17 Dr. Tammy Ho. I'm a nephrologist with North Shore
18 University Health Systems, and I'm here today on behalf of
19 my group, as well as my Division Chief, Dr. Stuart Sprague.
20 He's Division Chief of the Division of Nephrology and
21 Hypertension at North Shore. And today I'm here in
22 opposition to the proposal 11-054, which is the proposal to
23 develop a new in-center hemodialysis facility in
24 Northfield, which is HSA 7, by Fresenius.

1 So, I want to start off by saying we are not,
2 as physicians, here to say that Fresenius provides bad care
3 or inferior care. They do not. But what we are here for
4 is to say that there is an opportunity for a choice of
5 providers, an opportunity for a choice of modalities, as
6 well as differences in the delivery of care to this
7 community that isn't currently there, and, specifically,
8 I'm speaking of the dialysis provider choice, which is
9 Satellite Dialysis, the not-for-profit organization. Now,
10 their proposal actually will be heard subsequent to this
11 proposal, and so I'll speak to that now.

12 Both Fresenius and Satellite have proposals
13 for new developments for in-center dialysis units, and
14 their proposed sites actually lie about three and a half
15 miles away from each other. Our concern as physicians is
16 that should Fresenius units be approved this morning, it
17 will significantly reduce the need for more stations in
18 this area, as well as this is in light of the fact that
19 Fresenius Hoffman Estates also had an expansion by three
20 chairs, as well as the approval of additional projects with
21 the U.S. Renal Care. If this occurs there will be a
22 significant decrease in likelihood for the project of
23 Satellite that they are proposing later in the day.

24 So, as physicians, we really do see the impact

1 of end-stage renal disease on our patients, and it's very
2 important to us to provide adequate, good quality care.
3 But I think even more importantly, it's how we provide that
4 care and how the patients transition into this stage of
5 their illness. I think for us it's very important that
6 they are able to work, to take care of their families, go
7 to school, and do whatever they want to do, and the
8 traditional in-center, three-shift dialysis system makes it
9 very difficult to achieve this. The third shift starts
10 around two to three o'clock in the afternoon, which is hard
11 for the mom who picks up the child at three; it's hard for
12 the person who gets off work at 4:30, 5 o'clock; it's hard
13 for the full-time student. And I think what we would like
14 to see is the choice of more flexibility in shifts in
15 dialysis. The choice of transitioning into self-care, home
16 care, to maximize normalcy of life for this disease
17 process.

18 Satellite Dialysis is well-respected in the
19 field of dialysis providing. It also has a history of very
20 outstanding quality of care, but even beyond that, it's
21 very innovative. It has lots of creative ideas of how to
22 provide flexibility of care to these patients who are on
23 dialysis, and its philosophies are different, more
24 integration of dialysis into the person's existing life

1 versus trying to rearrange life around dialysis itself.
2 So, as physicians, we really feel that this is missing in
3 the community, currently and we would love to be able to
4 provide that to our patients. We think it's a critical
5 part of their care.

6 So, if the Board decides that there only can
7 be one additional unit in HSA 7, we respectfully request
8 that it be a different choice for our patients and that it
9 be Satellite Dialysis. Thank you very much.

10 CHAIRMAN GALASSIE: Thank you.

11 MR. BERKOWITZ: Good morning. I am a dialysis
12 patient and the President and founder of NxStageUsers, the
13 largest patient organization dedicated to home dialysis.

14 I will speak against the care and quality that
15 Fresenius gives. I was a Fresenius patient before becoming
16 a home patient. If I had not changed, I would not be here
17 to speak to you today; I would be dead. There are many
18 things that happened at Fresenius that should not happen at
19 any other center, but let's go beyond that right now.

20 Let's talk about the dialysis system in the
21 United States today. It's broken. It's broken because the
22 outcomes of dialysis in the United States ranked 37th in
23 the industrialized world. The cost is the greatest.
24 There's a problem. We have duopoly that exists in this

1 country that's made up of Fresenius, the number one
2 provider, and DaVita the second. Because of this, the
3 situation stifles competition and innovation. With the
4 Fresenius model of vertical integration, where they have
5 companies within both manufacturing, supplies and
6 pharmaceuticals, there is a problem when new innovation
7 takes place, because these companies cannot sell into
8 Fresenius. And so, therefore, we need to look at the
9 structure of dialysis in the country.

10 Regarding patient quality of care, the
11 original intent of the Medicare entitlement in 1972 was to
12 rehabilitate patients so they can be restored to their
13 prior lives, basically meaning being employed. However,
14 the rate of employment of those between the ages of 18 and
15 54 is only 21 percent. Those employed part-time or
16 full-time through rehabilitative actions by their providers
17 is only 2 percent. The number of facilities that have new
18 shifts after five p.m. is only 24 percent.

19 MR. MORADO: Thirty seconds.

20 MR. BERKOWITZ: There is a direct correlation
21 between those figures. We need that fourth shift. We
22 actually need a fifth shift. I respectfully disagree with
23 the Chairman.

24 Regarding patient safety, if you look at the

1 two applications, Fresenius is looking at a
2 staff-to-patient ratio of one to four, whereas Satellite is
3 looking at one to three. That totally relates to safety.
4 I know. I was in a Fresenius -- I was in a Fresenius unit
5 doing nocturnal. I ask people, "What do you think they
6 used as a lamp when the lights went out?" People usually
7 say, "Oh, they used a flashlight." I would say, "That
8 would be good. They used the five-inch colored TV to shine
9 light on us if we needed to be dealt with."

10 MR. MORADO: Wrap up your comments.

11 MR. BERKOWITZ: I have problems with that.
12 And considering DaVita is a billion dollar company, how
13 could they not not put twenty-dollar lamps at each station?
14 It was a tragedy. It was a travesty as well.

15 You know, I think that we need to look at the
16 whole landscape of dialysis in this country, and I think
17 you, as a Board, have the opportunity of making a change
18 now in Illinois by having a non-profit come in where it's
19 been shown that the mortality rate is lower than with the
20 two for-profits. That was my comments in -- well, for
21 Satellite. But anyways, I hope the Board takes this at
22 heart and realizes that it has a responsibility to patients
23 like me and to others who are not here to speak for
24 themselves. We're only hearing from the corporations. If

1 you would listen to the patient --

2 CHAIRMAN GALASSIE: Close please, sir.

3 MR. BERKOWITZ: If you listen to the patients,
4 you would hear a totally different story. Thank you.

5 CHAIRMAN GALASSIE: Thank you. And your
6 association represents how many people?

7 MR. BERKOWITZ: Our association represents
8 over 500 people, and they're all home-dialysis patients.

9 CHAIRMAN GALASSIE: In Illinois?

10 MR. BERKOWITZ: No, nationwide.

11 CHAIRMAN GALASSIE: Thank you.

12 MR. HYLAK-REINHOLTZ: Good morning, Chairman
13 Galassie, members of the Board, Staff members. My name is
14 Joe Hylak-Reinholtz. I am legal counsel to Satellite
15 Dialysis, an applicant who you will be considering later
16 this morning, or perhaps the afternoon. I have extensive
17 experience with the CON process, being a lawyer for
18 applicants but also many of you new members might not know,
19 I was an ex-officio member on this Board for about three
20 and a half years. So, I've sat on both sides of this table
21 and always appreciate the opportunity to come here today.

22 The purpose of my comments are to briefly
23 summarize Satellite's official position that it took in its
24 letter of opposition filed with regards to the Fresenius

1 Northfield application. First, it's not -- as Dr. Ho
2 summarized, it's not about the quality of care; it's more
3 about offering increasing choices and increasing the
4 alternative therapies that are available in the proposed
5 service area.

6 We're also concerned about the placement on
7 the agenda. We recognize this Board follows a first-come
8 first-serve process when reviewing applications. There's
9 no batching, no comparative review. We are, unfortunately,
10 last, and as the applicants continue to come up before you,
11 the HSA need in Area 7 continues to diminish. We hope this
12 Board will not hold that against us, just for the purpose
13 of being last on the agenda.

14 We also are concerned about under utilization
15 in the area, just like this Board is, but we think there is
16 a greater story about under utilization that should
17 recognize, take into account, alternative dialysis
18 therapies. We will be happy to talk extensively about that
19 when we provide our remarks later today. It's about under
20 utilization, as well, from providers who dominate the
21 market. If you allow facilities to continue to be in an
22 area that is only owned by one company, offer one way of
23 thinking, if those facilities never achieve utilization of
24 80 percent, the door is closed for new providers like

1 Satellite, or yesterday like U.S. Renal Care. In fact, if
2 you look at the Board's data -- not the Board's data, the
3 most recent data from the ESRD Network for utilization, 68
4 percent of existing Fresenius facilities are below this
5 Board's 80 percent standard. To be fair, we'll take out
6 those homes or those facilities that are new, less than two
7 years in operation. Still, one of two Fresenius facilities
8 are not at this Board's occupancy standard.

9 MR. MORADO: Thirty seconds.

10 MR. HYLAK-REINHOLTZ: We hope you would
11 recognize that when considering their application today.

12 We also wanted, in our letter, to affirm
13 Satellite's commitment to providing services to those in
14 need who cannot afford care, and lack of access to their
15 services. Again, we will talk about that in greater detail
16 today.

17 In sum, Satellite is hoping today to have a
18 fair hearing before this Board and to consider the
19 different therapies and alternate options that will be made
20 available if their application is approved. Thank you.

21 CHAIRMAN GALASSIE: Thank you.

22 That's it for public comment. Thank you,
23 ladies and gentlemen.

24 Just a reminder, as I mentioned yesterday, our

1 Board rules do call for a two-minute public comment. So,
2 the four of you yet to give public comment might want to
3 take a look at your comments. We try to be gracious and
4 respectful, but we also have an agenda to get through. So,
5 we appreciate your trying to give attention to that.

6 If the folks that were introduced and sworn in
7 would come to the table again, we'd appreciate that.
8 Introduce yourselves, please, and then -- you already
9 introduced yourselves. You need to be sworn.

10 (Oath given.)

11 CHAIRMAN GALASSIE: Thank you.

12 Mike, if you would give Staff report, please.

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

14 The applicants are proposing the establishment
15 of a 12-station ESRD facility, located in approximately
16 8,000 gross square feet of leased space in Northfield,
17 Illinois. The cost of the project is approximately \$3.6
18 million. The anticipated project completion date is
19 December 31st, 2013. No public hearing was requested. We
20 did not receive any letters of support. We did receive
21 opposition comment.

22 There is a calculated excess of 21 stations in
23 the HSA 7 Planning Area. This reflects 3 stations that I
24 mentioned yesterday that updated the 8 that were added

1 after the reports were released. That's why my numbers
2 differ from Ms. Olson's numbers.

3 CHAIRMAN GALASSIE: How many letters of
4 opposition?

5 MR. CONSTANTINO: I have one.

6 CHAIRMAN GALASSIE: Thank you.

7 Good morning. Who would like to speak to
8 Board on this issue?

9 MS. RANALLI: Good morning. I'm going to turn
10 this over to Dr. Nora and Dr. Patel, but I did want to
11 mention, because this is a little bit different -- our
12 Evanston facility is under utilized, and it has been
13 historically. It's a large unit. So, we're proposing
14 taking eight stations from that facility and sort of
15 relocating them, if you will, to the proposed Northfield
16 facility, where we see more of a need for service. And I
17 also just wanted to point out Table Five of the
18 application. You just heard a comment that there was one
19 provider in the area and there had to be a choice. 45
20 percent of the facilities within a 30-minute radius are not
21 Fresenius facilities. So, there is a choice in this area.
22 MR. URSO: Clare, can I ask you a question?
23 Is that reduction at that facility part of this
24 application?

1 MS. RANALLI: Yes, yes, right.

2 CHAIRMAN GALASSIE: Dr. Nora.

3 MS. NORA: Thank you very much. I -- this is
4 only my second hearing like this, so excuse me. I am a
5 little overwhelmed. I thought that this was to determine
6 whether there was a need for more dialysis units. So, I
7 don't want to get on with the problems that we are all
8 aware of with dialysis in this country and things like
9 that. I am here to speak that we need more dialysis chairs
10 in this area in Northfield. Our practice is growing.
11 Unfortunately, you all recognize the dialysis population in
12 this country continues to grow. Aging population, obese
13 population continues to grow, and I specifically say aging.
14 So, I thought that that was the main point, whether we
15 needed more dialysis stations. So I would just like to
16 stress that we definitely do.

17 CHAIRMAN GALASSIE: It is the main point.

18 MS. NORA: As far as alluding to what came
19 earlier, whether there should be another provider in the
20 area, I am not expert at that. I would like to, however,
21 say that I would strongly agree with Dr. Ho and
22 Mr. Berkowitz, that the model of three times a week
23 in-center dialysis is not optimal. It works very well for
24 many people. It's the only alternative for many people.

1 But it is not perhaps -- certainly not the only and perhaps
2 not the optimal way. I just want to stress that Fresenius
3 does offer home dialysis, utilizing the exact same
4 technology, the same machines that Mr. Berkowitz has been
5 so successful with. As a matter of fact, we have sent
6 patients from our practice to the Wellbound unit in
7 Evanston in the past when Fresenius did not offer that
8 technology, so our patients could get that.

9 I would like to stress that the Deerfield
10 unit, the Fresenius Deerfield unit has home dialysis
11 patients using both peritoneal dialysis and Next Stage
12 home, hemodialysis therapy. One thing I can speak to to my
13 practice, and perhaps the Northbrook, Highland Park, Lake
14 Forest area, is that, unfortunately or fortunately, my
15 population is very elderly. We have not found them as
16 willing or to have a partner -- many of our patients are
17 widows or widowers or they don't have a partner at home.
18 They are very reluctant to put needles into their arms and
19 to dialyze alone. So, it's not -- it is an excellent
20 modality. It's a modality I wish more people had, but it
21 is not a modality for everybody.

22 Lastly, I would like to say that I think for
23 some patients -- I think the whole thing about integrating,
24 I would agree again with Mr. Berkowitz. I think we need

1 four shifts, I think we need five shifts. We run in the
2 Highland Park unit, an independent unit that I'm Medical
3 Director of, a nocturnal dialysis program where patients do
4 spend the night on dialysis, three times a week. I agree
5 we need more choices and more openness to new technology,
6 different ways of doing things. But I would just like to
7 say that we need more in-center dialysis stations in this
8 area.

9 CHAIRMAN GALASSIE: Thank you very much.

10 Dr. Patel, did you want to make comments?

11 MS. PATEL: Thank you very much.

12 I tend to agree with Dr. Nora. The particular
13 area where we are and the approximate age of our patients
14 is about 85 years, and having tried to push home dialysis
15 where I am the Director, I've been quite unsuccessful, even
16 with the help of caregivers, because they would never pick
17 up the courage to do it at home. I know that we are told
18 that age is no limit, it gives you independence, but those
19 patients, unfortunately, feel very secure in a monitored
20 area. So, having been a Director of a home dialysis
21 program, that has been the biggest challenge for me to grow
22 that program. So, I think we come from -- the location
23 where this unit is proposed, we do have a very elderly
24 population, which I think does not like to commute in the

1 winter months. They would be very secure if there was less
2 distance. I don't think they care about the under
3 utilization or over utilization, as long as the dialysis
4 unit is with three blocks or four blocks from where they
5 live. They really do want to go there.

6 There have been times in my facility that
7 there were issues with the electricity, where there was a
8 storm, and my patients would not get dialyzed and could not
9 arrange to other dialysis units, where they could travel,
10 because they had some issues with the commute. So, I
11 understand the issues that come up, but what me and
12 Dr. Nora agree on is there a need for a dialysis unit.
13 There is a wonderful place for a home-run program for
14 independence. Unfortunately, our population is not the one
15 that is asking for a home program. It comes from our
16 patients' hearts, from the patients' needs, not from the
17 physician, not from the dialysis, whether it's DaVita or
18 Fresenius or whichever unit. I think all of us as
19 physicians are, by CMS standards, regulated to care.
20 Whether I'm a Director of Fresenius or DaVita or Satellite
21 doesn't matter. We are held to the same standards of care
22 as a nephrologist in the whole country, and I think to
23 propose one unit over the other is not what I look forward
24 to, whether I'm a Director of Fresenius, Director of

1 DaVita, or Satellite. Whether the patient has insurance,
2 no insurance, whether it's elderly or young, we are
3 expected to be held to the same standard of care, and I
4 think -- we all have the answers to the patients' needs or
5 the geographical area of where we're located at. I think
6 we have two wonderful units. We are very satisfied with
7 our units. We have grown the units to 80 percent, 70
8 percent. We have seen growth in this area, and especially
9 when there is a -- when we pull some chairs from the
10 Evanston unit to this unit -- I think we are asking for
11 four or five more chairs -- I think that will really serve
12 our elderly population, and that would be in their best
13 interests.

14 CHAIRMAN GALASSIE: Thank you very much.

15 MR. BRANDENBURG: Just one quick comment.
16 These particular physicians use our treatment options
17 program extensively. In their pre-ESRD patient
18 populations, those patients are being educated on
19 therapies, like home, in-center, transplantation. So,
20 there's an extensive use of those resources to educate
21 patients as much as possible, even though there are certain
22 challenges, depending on patient's age or status. But the
23 information is being provided to them, and certainly these
24 physicians are very, very active in that.

1 CHAIRMAN GALASSIE: Thank you very much.

2 I would like to open it up to the Board for
3 any questions you may have.

4 MR. BURDEN: I have one question,
5 Mr. Chairman.

6 CHAIRMAN GALASSIE: Yes.

7 MR. BURDEN: It appears obvious that we have a
8 batting line-up that causes one competing unit to feel that
9 if we act positively on Project 11-054, it puts them at a
10 disadvantage to come up this afternoon. How do we
11 effectively handle that question that I heard presented?

12 CHAIRMAN GALASSIE: It is what it is. People
13 understand that.

14 MS. RANALLI: I would like to point out,
15 too --

16 CHAIRMAN GALASSIE: I don't know that this is
17 an appropriate time to comment, Claire. I would like to
18 keep it open to Board comments now.

19 MS. RANALLI: But it's responsive to his
20 comment, Chairman Galassie. I'm sorry.

21 CHAIRMAN GALASSIE: I don't think we need a
22 response. I'd like to open it up to Board questions.

23 Any questions from Board members?

24 MR. HAYES: I have a question. You mentioned

1 that your Evanston facility is -- what is going to happen
2 with that?

3 MS. RANALLI: Eight stations will be
4 eliminated from that facility, and this proposed facility
5 in Northfield will have twelve stations. So, what we're
6 doing is addressing your utilization criteria, because the
7 current Evanston facility is between 50 and 60 percent
8 utilized, and it has been for some time and, therefore, to
9 correct that, we are eliminating eight stations so that it
10 will be at 80 percent utilization, approximately. We're
11 then proposing that the Northfield facility with, Doctors
12 Nora and Patel, who have a population that needs to be
13 served, have twelve stations. So, what we are doing is
14 we're only adding four stations to the inventory, whereas
15 the other project is adding sixteen. And since you have
16 commented on the excess capacity issues, we're trying to
17 accommodate the patient need while also addressing your
18 concerns, according to your inventory, about capacity.

19 MR. HAYES: Mike, in this case, on this
20 application, they're able to -- does this application for
21 Fresenius Medical Center Northfield, does that include the
22 discontinuation of eight stations at the Evanston facility?

23 MR. CONSTANTINO: If you would approve the
24 project, the Permit Letter would read, "This project is

1 approved for the establishment of 12 stations and the
2 discontinuation of 8 stations at the Evanston facility."
3 They could have done this discontinuation of these eight
4 stations at Evanston with just a letter to us, but they
5 brought that to the board with this application. A
6 discontinuation of stations just requires a letter to us
7 and no further action.

8 MR. HAYES: How many stations are currently at
9 Evanston?

10 MS. NORA: Twenty stations.

11 MS. AVERY: Mr. Hayes, 20 stations with 50
12 percent utilization.

13 MR. HAYES: Thank you.

14 CHAIRMAN GALASSIE: Thank you.

15 MR. HILGENBRINK: Mr. Chairman, just so I'm
16 clear on this, it isn't contingent on reducing that, you
17 won't reduce it if we don't approve this; is that what
18 you're saying?

19 MS. RANALLI: Not as part of this application,
20 no.

21 MR. HILGENBRINK: If this application does not
22 pass, then you won't reduce stations, is that correct?

23 MR. BRANDENBURG: That hasn't been part of the
24 discussion.

1 MR. HILGENBRINK: I'm asking the question. If
2 this application fails, will you not -- will you continue
3 those other stations in that facility.

4 MR. BRANDENBURG: I don't have an answer for
5 that right now.

6 MR. CONSTANTINO: Mr. Hilgenbrink, your rules
7 allow them to discontinue stations with just a letter to
8 us. If they decide to discontinue those eight stations,
9 all they have to do is submit a letter and those stations
10 are taken out of the inventory. They did this as part of
11 the application, to bring to the Board that they were going
12 to do this, as part of this application while they're
13 adding these twelve stations. If you do not approve this,
14 those eight stations will not be taken out of the inventory
15 unless they submit a letter to us.

16 CHAIRMAN GALASSIE: Final comment. Dr. Nora?

17 MS. NORA: Again, I just wanted to really
18 stress that the important thing is to provide the best
19 possible care to the patients, and I just want to stress,
20 as I think our application does, our practice continues to
21 grow. The need continues to grow. When I was here 18
22 months ago, I explained where we were at. It was suggested
23 to get a third partner. We did. We needed it. It's a
24 growing population, and I would just like you to really

1 consider that it's very hard for these people to drive some
2 of the distances that they are already driving. Many of
3 these people rely on Medivans, et cetera, to get back and
4 forth to treatments. I have elderly people that are
5 frightened right now because it's getting dark at night and
6 the only shift that is now available to them is the one
7 that starts at three or four o'clock, which means they have
8 to try to drive home at eight o'clock at night.

9 So, again, I am confident of the quality that
10 all the major providers deliver. If there is fault, it is
11 perhaps with the doctor, his close attention to the
12 patient.

13 The other thing I'd like to do is stress that
14 if we spread ourselves too thin and we tell patients, "I
15 don't want to drive this far. Go to a different unit.
16 I'll get there once in a blue moon and make sure you're all
17 right." It's important that our patients be taken care of
18 by the doctors that know them and take care of them that
19 can get to them frequently and are closer to the units.
20 So, I would just like to stress the need for a dialysis
21 unit.

22 CHAIRMAN GALASSIE: Thank you very much.

23 I'm going to call for a motion to approve
24 Project 11-054 for the establishment of a twelve-station

1 ESRD facility in Northfield, Illinois.

2 MR. BURDEN: So moved.

3 MR. SEWELL: Second.

4 CHAIRMAN GALASSIE: Motion and a second.

5 Roll call, please.

6 MR. DART: Motion made by Dr. Burden.

7 Seconded by Mr. Sewell.

8 Dr. Burden?

9 MR. BURDEN: I'm going to vote yes on this
10 application, which increases the number of beds by four,
11 somewhat dependent on the knowledge that I know the
12 physicians involved and, by reputation, they will do what
13 they claim. So I vote yes.

14 MR. DART: Mr. Eaker?

15 MR. EAKER: I'll vote 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: Abstain.

24 MR. DART: Mr. Sewell?

1 MR. SEWELL: Yes.

2 MR. DART: Chairman Galassie?

3 CHAIRMAN GALASSIE: Chair votes yes.

4 CHAIRMAN GALASSIE: Motion passes. Thank you
5 very much. And I'd like to thank the physicians and our
6 patient advocate personally. I'm finding the education
7 process informative. It's a learning process, at least for
8 me. Reinforces Dr. Burden's desire to have us initiate a
9 retreat.

10 Do the Board members -- it's 11:30. Lunch is
11 at 12:30. Do you desire a ten-minute stretch? Yes?
12 Ten-minute stretch. We will come back here at twenty until
13 twelve.

14 (Recess)

15 CHAIRMAN GALASSIE: We are going to move the
16 agenda. No. 11-057, there is no public comment.

17 If you folks would reintroduce yourselves for
18 the record. You're already sworn.

19 MS. RANALLI: Clare Ranalli, Lori Wright, and
20 Connie Muldoon.

21 CHAIRMAN GALASSIE: Thank you.

22 Staff report, please.

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

24 The applicants are proposing the addition of

1 two stations to an existing 22 station ESRD facility
2 located in approximately 10,000 gross square feet of leased
3 space in Melrose Park. The cost of the project is
4 approximately \$44,350. The anticipated project complete
5 date is December 31st, 2012. No public hearing was
6 requested, and no letters of support or opposition were
7 received.

8 Thank you, Mr. Chairman.

9 CHAIRMAN GALASSIE: Do Board members have any
10 questions in this regard? I'm not sure we need a lengthy
11 presentation. We're going from 22 to 24.

12 MS. OLSON: I have one quick question. What
13 is the current utilization at this site?

14 MS. WRIGHT: It's at the 90 percent
15 approximately, 96 percent.

16 CHAIRMAN GALASSIE: Any other questions by
17 Board members?

18 Hearing none, may I have a motion to approve
19 Project 11-057, to add two ESRD stations to an existing
20 22-station facility in Melrose Park, Illinois?

21 MR. EAKER: So moved.

22 MR. BURDEN: Second.

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

1 MR. DART: Motion made by Mr. Eaker, seconded
2 by Dr. Burden.

3 Dr. Burden?

4 MR. BURDEN: Yes.

5 MR. DART: Mr. Eaker?

6 MR. EAKER: Yes.

7 MR. DART: Justice Greiman?

8 MR. GREIMAN: Yes.

9 MR. DART: Mr. Hayes?

10 MR. HAYES: Yes.

11 MR. DART: Mr. Hilgenbrink?

12 MR. HILGENBRINK: Yes.

13 MR. DART: Ms. Olson?

14 MS. OLSON: Yes.

15 MR. DART: Mr. Sewell?

16 MR. SEWELL: Yes.

17 MR. DART: Chairman Galassie?

18 CHAIRMAN GALASSIE: Chair votes yes.

19 MR. DART: Eight votes in the affirmative.

20 CHAIRMAN GALASSIE: Motion passes. Thank you
21 very much.

22 Moving on to Item 11-058, Fresenius Medical
23 Care, Plainfield. Again, no public comment. Staff report,
24 please.

1 MR. CONSTANTINO: Thank you, Mr. Chairman.
2 The applicants are proposing the addition of 4 ESRD
3 stations to an existing 12-station ESRD facility located in
4 approximately 6,000 gross square feet of leased space in
5 Plainfield, Illinois. The cost of the project is
6 approximately \$102,000. The anticipated project completion
7 date is December 31st, 2012. No public hearing was
8 requested, and no letters of support or opposition were
9 received by the State Board staff.

10 CHAIRMAN GALASSIE: And utilization rate?

11 MR. CONSTANTINO: Currently it's 90.3 percent.
12 However, your standard requires them to be at 80 percent
13 for two years. That's why we're negative on this report.

14 CHAIRMAN GALASSIE: Thank you very much.

15 Comments for the Board? I think this
16 gentleman needs to be introduced and sworn.

17 MR. TUNGI: My name is Dr. Tunji Alausa
18 (spells name). I'm the Medical Director for the facility.

19 MS. RANALLI: I'm going to turn this over to
20 Dr. Alausa. Essentially, this clinic hasn't been operating
21 for two years. That's the reason we don't meet your
22 criteria yet, but it grew so exponentially for so many
23 patients in this area, that it's already at 92 percent, and
24 we need to accommodate for future growth.

1 CHAIRMAN GALASSIE: So let me just suggest,
2 if you're at 92 percent right now and we're going from 12
3 to 16 beds -- stations, excuse me, it sounds pretty
4 straightforward. I would suggest, Doctor, respectfully,
5 I'd be happy to hear your comments.

6 But are there questions from the Board that
7 they want to ask.

8 MR. GREIMAN: I have a question.

9 CHAIRMAN GALASSIE: Judge.

10 MR. GREIMAN: I just want to know why the --
11 there is such a drop in the charitable care from the number
12 of patients. It's actually half in 2010 as it was two
13 years previously. And, of course, Medicaid is almost -- is
14 significantly higher, but the charity is incredibly cut.
15 Why is that?

16 MS. RANALLI: The numbers you're referring to
17 are state-wide numbers, of course, not for this particular
18 project.

19 MR. GREIMAN: Right, I know that.

20 MS. RANALLI: I just wanted to make sure,
21 because there was some dialogue before. The charity care
22 numbers, again, reflect what's uncompensated treatments,
23 treatments to people who don't have coverage. They may get
24 it, but they don't have it when they receive treatments,

1 and those numbers have gone down dramatically, because we
2 have worked very carefully with the patient population that
3 for whatever reason does not have coverage to get it in
4 place for them. In Illinois, undocumented patients are
5 entitled to receive Medicaid. We help those patients
6 obtain Medicaid coverage. There are options available
7 through the American Kidney Foundation for coverage, and
8 Fresenius has worked very, very hard in Illinois to make
9 sure -- in the last few years to make sure we get coverage
10 for the patients who are eligible for it. Therefore, the
11 charity numbers go down, the Medicaid numbers go up.

12 MR. GREIMAN: So they relate to each other;
13 the charity patients and the Medicaid actually have
14 relative issues; is that what you're talking about?

15 MS. RANALLI: Yes.

16 MR. GREIMAN: Thank you.

17 CHAIRMAN GALASSIE: Member Sewell?

18 MR. SEWELL: I wanted to ask the Staff, what's
19 the excess capacity in HSA 9? Yesterday she said about 55.

20 MR. CONSTANTINO: It's 68 now in HSA 9.

21 MR. SEWELL: You know, just a comment.

22 There's this universal dilemma we always have between
23 institutional need and need in the community. The
24 geometric increase in occupancy that was cited points to an

1 institutional need, when it doesn't appear that there is a
2 need in the Service Area for additional capacity, and
3 that's the tension we live with on all of these
4 applications.

5 MS. WRIGHT: Could I just address that real
6 quick? For a place like HSA 9, which a part of it is
7 Joliet, Bolingbrook, Plainfield area, heavily populated --
8 the rest of the HSA lies in rural areas, and most of the
9 rural clinics generally never get to operate six shifts.
10 Part of it is population; part of it is the patients are
11 traveling the rural roads, they don't want to travel in the
12 evenings. These facilities just do not operate the last
13 shift of the day, and that kind of skews the overall
14 utilization and the need, where I think it's higher in the
15 more populated areas.

16 CHAIRMAN GALASSIE: Thank you.

17 MR. HAYES: Mr. Chairman.

18 On the need analysis here, basically what --
19 we were talking before on another application, and I
20 shouldn't lump these all together, but, basically, we're
21 looking at what, a need analysis from about 2008 or 2009,
22 the numbers you were using are based on need analysis from
23 2008 or 2009?

24 MS. RANALLI: Well, the -- correct, the need

1 analysis, yes, although the Plainfield facility opened in
2 2009 or late 2008.

3 MR. TUNJI: We're using the most recent number
4 of patients.

5 MR. HAYES: Mike, when you calculate your need
6 analysis for HSA 9, is there -- you use a September 2011
7 inventory?

8 MR. CONSTANTINO: Yes.

9 MR. HAYES: So, that's calculated on updated
10 numbers?

11 MR. CONSTANTINO: Currently, as of this
12 moment, there's, our calculation shows, 68 stations in
13 excess in HSA 9.

14 MR. HAYES: And did you base your analysis on
15 those numbers?

16 MS. RANALLI: You mean for the addition of
17 four stations to this facility?

18 MR. HAYES: Yes.

19 DR. TUNJI: Yes, it was based on that, but the
20 HSA number counts all the dialysis stations in the
21 facility. As Mr. Sewell said, there's need for
22 community -- it's more of a community need, not an HSA
23 need.

24 MR. HAYES: Thank you.

1 MR. URSO: Correct me if I'm wrong, Mike, but
2 they couldn't have used the excess that is currently in
3 front of the Board, because this is the excess that's been
4 generated based upon Board actions within the last day and
5 a half; am I right, Mike?

6 MR. CONSTANTINO: They used an excess of 55,
7 and then over the last day and a half that's changed.

8 MR. URSO: The number has changed based upon
9 the Board approvals.

10 MR. CONSTANTINO: In a situation like this
11 with Plainfield, they're adding four stations. We're asked
12 to look at whether or not they've been at 80 percent
13 utilization for the last two years, and they have been not
14 operating for two years. So, they didn't meet that
15 requirement. That's why we are negative on this report.
16 Currently, as of today what they're telling me, they're at
17 90-plus percent occupancy.

18 MR. SEWELL: Let me understand this. I heard
19 something embedded in your comment. I want to get it
20 straight now. So, even if there's excess capacity in a
21 Health Service Area, our rules would allow someone to add
22 additional capacity if the -- if they had 80 percent
23 occupancy in two years?

24 MR. CONSTANTINO: That's correct, sir.

1 MR. SEWELL: That's interesting.

2 MR. URSO: Claire or members of the panel, how
3 long have you been at this utilization that we're talking
4 about, since you don't meet the two-year? How long have
5 you --

6 DR. TUNJI: Over six months now. Patients are
7 having to do fourth shift, and it makes me feel sad. I had
8 to turn down a patient just last week because it was so
9 hard for them to get there for the fourth shift. So, it's
10 very sad. This isn't something any physician wants to deal
11 with.

12 MS. WRIGHT: We reached 80 percent utilization
13 this past January. We were open one year. So, we've been
14 at 80 percent for about 10 months.

15 CHAIRMAN GALASSIE: Any other questions from
16 Board members?

17 Hearing none, may I have a motion to approve
18 Project No. 11-058 to add four ESRD stations to an existing
19 ESRD facility in Plainfield, Illinois?

20 MS. OLSON: So move.

21 MR. SEWELL: Second.

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

24 MR. DART: Motion made by Ms. Olson, seconded

1 by Mr. Sewell.

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: Well, because of the excess in the
10 HSA 8 area, I'm going to vote no.

11 MR. DART: Mr. Hilgenbrink?

12 MR. HILGENBRINK: Yes.

13 MR. DART: Ms. Olson?

14 MS. OLSON: Yes, based on if this application
15 was submitted today, there would be a positive finding from
16 the Staff.

17 MR. DART: Mr. Sewell?

18 MR. SEWELL: Yes.

19 MR. DART: Chairman Galassie?

20 CHAIRMAN GALASSIE: Chairman votes yes.

21 MR. DART: That's 7 votes affirmative, one no.

22 CHAIRMAN GALASSIE: Thank you very much.

23 We are moving to 11-059, Fresenius Medical

24 Care in Logan Square. There is no public comment. As a

1 result, this gentleman that just came up, would you give us
2 your name, spell it, and be sworn in, please?

3 MR. STOTZ: Rick Stotz (spells name).

4 (Oath given)

5 CHAIRMAN GALASSIE: Thank you.

6 Staff report, please.

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

8 The applicants are proposing the establishment
9 of a 12-station ESRD station located in 7,000 gross square
10 feet of leased space in Chicago, Illinois. The cost of the
11 project is approximately \$3,100,000. The anticipated
12 project completion date is December 31st, 2013. No public
13 hearing was requested, and no letters of support or
14 opposition were received.

15 I would like to point out there is a
16 calculated need for 41 stations in this HSA 6, ESRD
17 Planning Area, which is the City of Chicago.

18 And I would like to ask everyone to speak into
19 the microphone. The Court Reporter is beating the hell out
20 of me over here.

21 (Laughter)

22 CHAIRMAN GALASSIE: In that case we're going
23 to pull away from the mics.

24 And because the Board will ask, utilization

1 rate?

2 MR. CONSTANTINO: It's a new facility, it's a
3 proposed new facility.

4 CHAIRMAN GALASSIE: Thank you.

5 Comments for the Board?

6 MS. RANALLI: The only negative in this
7 facility, which is finally coming home to my neighborhood,
8 is on the size of the facility. It's slightly over per
9 station, and that was due to just finding the right space.
10 Sometimes it's hard to find space that directly
11 accommodates the size per station, but we did our best and
12 besides that --

13 MR. STOTZ: Room for future expansion, as
14 well.

15 CHAIRMAN GALASSIE: Good to hear. What we
16 need.

17 Questions from Board members? Mr. Sewell?

18 MR. SEWELL: So, this is leased space, so you
19 have some limitations on controlling within the standard;
20 is that correct?

21 MR. STOTZ: Yes, sir.

22 MR. SEWELL: So, what are the consequences?
23 We have this standard because of a cost concern, right? We
24 don't want to over invest in the space. How much money are

1 we talking about in terms of a lease per square foot, so we
2 can figure out how much more it's costing because the size
3 is too big?

4 MS. RANALLI: It's 63 gross square feet per
5 station. The total lease cost for a 10-year lease is \$913,
6 000. Do you have a calculator? Maybe we could figure that
7 out.

8 MR. SEWELL: Right. I got it. It's not
9 significant.

10 CHAIRMAN GALASSIE: No.

11 Other questions? Dr. Burden?

12 MR. BURDEN: Mr. Stotz -- is that correct?

13 MR. STOTZ: Yes, yes.

14 MR. BURDEN: And your relationship with this
15 application is?

16 MR. STOTZ: I'm the Regional Vice-President,
17 overseeing the project.

18 MR. BURDEN: Who are the physicians that are
19 going to be seeing the patients in this unit?

20 MR. STOTZ: Dr. Kraemer, Associates in
21 Nephrology, AIN.

22 MR. BURDEN: Does he have partners?

23 MR. STOTZ: The AIN Nephrology Group, it's a
24 large practice in Chicago.

1 MR. BURDEN: What hospitals are you associated
2 with?

3 MR. STOTZ: Most of them in the City of
4 Chicago.

5 MR. BURDEN: There are a lot of them in the
6 City of Chicago. You don't know any of them?

7 MR. STOTZ: Illinois Masonic.

8 MR. BURDEN: Okay. Good.

9 CHAIRMAN GALASSIE: Other questions?

10 (Pause)

11 CHAIRMAN GALASSIE: Hearing none, may I have
12 a motion to approve Project 11-059 for the establishment of
13 a 12-station ESRD facility in Chicago, Illinois?

14 MR. EAKER: So moved.

15 MR. BURDEN: Second.

16 CHAIRMAN GALASSIE: Moved and seconded.

17 MR. DART: Motion made by Mr. Eaker, seconded
18 by Dr. Burden.

19 Dr. Burden?

20 MR. BURDEN: Yes.

21 MR. DART: Mr. Eaker?

22 MR. EAKER: Yes.

23 MR. DART: Justice Greiman?

24 MR. GREIMAN: Yes.

1 MR. DART: Mr. Hayes?

2 MR. HAYES: Yes.

3 MR. DART: Mr. Hilgenbrink?

4 MR. HILGENBRINK: Yes.

5 MR. DART: Ms. Olson?

6 MS. OLSON: Yes.

7 MR. DART: Mr. Sewell?

8 MR. SEWELL: Yes.

9 MR. DART: Chairman Galassie?

10 CHAIRMAN GALASSIE: Chairman votes yes.

11 MR. DART: Eight votes in the affirmative.

12 CHAIRMAN GALASSIE: Motion passes.

13 Congratulations. Thank you.

14 Moving on to Item 11-061, Satellite Dialysis
15 of Glenview. We do have four public comments, three in
16 support, one in opposition. If our public comment folks
17 will come forward, we will read your names, and you can cue
18 up, please. Just a reminder for our public comment, we do
19 ask for a two-minute comment and we, again, try to be
20 gracious, but we have ample agenda to get through for the
21 rest of the day. So, please be direct and please be timely
22 and please don't be insulted if we gavel you out.

23 MS. AVERY: For public comment we have Jackie
24 Walker, Allison Meyers, Richard Berkowitz, and Rick Stotz

1 in opposition.

2 CHAIRMAN GALASSIE: Mr. Berkowitz, welcome
3 back.

4 MR. BERKOWITZ: Thank you very much. I'm
5 talking in support of the Satellite healthcare facility in
6 Glenview. In addition to being the President and Founder
7 of NxStageUsers, I'm also on the Satellite Healthcare
8 Grassroots Committee, which works with the Director of
9 Government Affairs and various Regional Directors and
10 social workers. I think we are the first organization to
11 actually set up a patient advisory committee, which is
12 supposed to be a dual-avenue communications effort between
13 management and patients. It's going to be set up within
14 all of the dialysis centers, both Satellite and Wellbound.
15 It's going to be a hierarchical format where there are
16 going to be representatives from each shift, and then there
17 are going to be representatives from each center, and then
18 all of a sudden, we'll probably, you know, somehow
19 coagulate into a national advisory committee for Satellite.
20 I think this is forward thinking on the part of the
21 company.

22 Satellite also has the largest percentage of
23 patients at home, in the country. I think that's because
24 of the education that they provide. I know that when I was

1 in a Fresenius unit, there was no education provided at all
2 to me at any level, and I think that the reason why more
3 patients aren't going home is because of education and also
4 because of the fact that many dialysis centers want to keep
5 their chairs full.

6 MR. MORADO: Thirty seconds.

7 MR. BERKOWITZ: I also believe that it's
8 really important to have multiple shifts. The Satellite
9 facility is planning on being open 7 days a week, which is
10 going to afford more people the ability of going to work,
11 and that's one of the things that we need to do. We have
12 an incredible deficit problem in this country, as everybody
13 knows. Most dialysis patients are receiving Disability
14 rather than paying taxes, and they are -- you know, so
15 that's one way that we can make a dent in it. And I urge
16 the Board to consider the Satellite proposal and permit.

17 CHAIRMAN GALASSIE: Thank you very much.

18 MS. MEYERS: Good afternoon. My name is
19 Allison Meyers (spells name). I am speaking in support of
20 the Satellite dialysis proposal. I've been on dialysis
21 myself for 9 years. Within that 9 years, I've been to
22 three dialysis units, two of them being Fresenius. I would
23 like for Satellite to be approved, because I would like
24 there to be a choice. I left the two Fresenius units

1 because I didn't feel that I was given the quality of care
2 that I should have been. I'm currently at a DaVita unit
3 that is half an hour away from my house, that I have to
4 travel to two three times a week.

5 The flexibility in the shifts that Satellite
6 is willing to offer would also be big. I am 39 years old,
7 and I have had two great jobs in the workforce where I
8 worked for myself, where I work out of my house, because a
9 lot of corporations will not hire a split-shift, so I can
10 get my dialysis done and completed. And the availability
11 of another dialysis will help to rectify the overcrowding
12 that there is in so many of the dialysis units in the area.
13 Thank you.

14 CHAIRMAN GALASSIE: Thank you.

15 Good morning.

16 MS. WALKER: Good morning. My name is Jackie
17 Walker, and I receive treatment at the Satellite Evanston
18 in Skokie, Illinois. I am here today to show support for
19 the request submitted by Satellite Dialysis in Glenview,
20 and it happens to be a great joy for me today to be able to
21 thank publicly Dr. Sprague and the outstanding staff at
22 Wellbound Satellite, because I have them to thank for my
23 life, and it's because of them that I do have a life.

24 Only a few weeks ago, Dr. Sprague, my

1 nephrologist, because of his high level of dedication and
2 outstanding medical expertise and willingness to think and
3 make decisions out of the box, that he literally saved my
4 life once again. The first time is with the dialysis and
5 the treatment of my kidney disease, and this time finding a
6 cancer that was hiding in my bladder, which, thank
7 goodness, was detected, safely removed, and I'm now
8 recovering well. The danger with this medical diagnosis is
9 that it will go undetected and it will not be found until
10 it becomes high drama. I had manifested a symptom that
11 could have easily been dismissed. However, Dr. Sprague
12 pushed for a CT scan, and the unexpected showed up and was
13 successfully dealt with. Needless to say, I have the
14 deepest attitude of gratitude and appreciation.

15 When I think about Wellbound, there are a few
16 topics that readily come to mind; first is that of having
17 choices. When it was clear that I would need to begin
18 dialysis and the one choice that I no longer could
19 entertain was that of not doing dialysis, Dr. Sprague and
20 his staff made every effort to inform me about my options.
21 He introduced me to Wellbound and his wonderful team of
22 healthcare practitioners. They made every effort to
23 educate me as to my choices and types of dialysis that are
24 available. And, by the way, this option of choices of

1 different types of treatment are not necessarily available
2 to all kidney patients.

3 MR. MORADO: Thirty seconds.

4 MS. WALKER: I'll skip a page.

5 CHAIRMAN GALASSIE: Thank you.

6 MS. WALKER: Okay. But no one ever looks
7 forward to the need of dialysis. However, when it is that
8 which gives one life, it is a gift and a blessing to have a
9 facility such as Wellbound and physicians such as
10 Dr. Sprague. The environment at Wellbound facility where I
11 receive treatment and the attitude of the staff allows one
12 to feel like family and not just a patient. Their
13 boundaries are impeccable, objective, and clear. However,
14 the patient's experience is that of caring and support.
15 How special is that in the medical environment? And from
16 this patient's point of view, what Wellbound Satellite is
17 about is that which we need more of in our medical culture.

18 I wish to thank Dr. Sprague and the Wellbound
19 Satellite team, one and all, for being the special
20 healthcare providers that they are and, most of all, I
21 thank them for my life. And thank you for allowing me the
22 opportunity to share with you today, and, of course, I ask
23 you to consider the possibility of a new center for
24 Wellbound in Glenview. Thank you.

1 CHAIRMAN GALASSIE: Thank you very much.

2 Mr. Stotz.

3 MR. STOTZ: Good afternoon. My name, again,
4 is Rick Stotz. I'm regional Vice-President for Fresenius
5 Medical Care. Thank you for the opportunity to address
6 concerns with Satellite's application.

7 I'd like to state for the record that we are
8 not against a competitor entering the market in Illinois,
9 and we view Satellite as a quality provider. We are not
10 here to oppose the Satellite project, but would like to
11 comment on the not-for-profit status of the applicant.

12 Satellite has much made of the fact that it is
13 a not-for-profit provider. However, the owner/operator of
14 the clinic appears to be a for-profit LLC organized in
15 Delaware. We look at Satellite's Form 990, which is its
16 public tax return, and it has many for-profit entities
17 listed that were excluded entities. What this means is
18 that their revenue is accounted for separately as
19 for-profit providers. The Glenview LLC was likely
20 organized as a Limited Liability Company in Delaware as
21 opposed to a not-for-profit in Illinois because it
22 eventually will solicit physician involvement. While many
23 dialysis clinics operate this way, it means that this clinic
24 will be a for-profit entity, despite its parent status as a

1 not-for-profit.

2 Satellite's arguments that it is a better
3 choice simply based on it being a not-for-profit has no
4 basis. The not-for-profit status of the LLC's parent does
5 not mean it will provide better care for expanded access to
6 patients based on pair source. Thank you.

7 CHAIRMAN GALASSIE: Thank you very much.
8 That closes public comment on this issue.
9 Thank you ladies and gentlemen.

10 If the representatives from Satellite Dialysis
11 of Glenview will come to the table. I would ask you to
12 introduce yourselves, speaking into the microphone and
13 spelling your names for our Recorder, and then be sworn in.
14 Thank you.

15 MR. BRANSON: Good morning. My name is Mark
16 Branson (spells name). I'm the Executive Vice-President of
17 Satellite Healthcare.

18 CHAIRMAN GALASSIE: Thank you.

19 MS. SCHILLEL: Good morning. My name is
20 Brigitte Schillel. I am the Chief Medical Officer of
21 Satellite Healthcare. (Spells name)

22 MR. NASH: Hello. I'm Kevin Nash. I'm a
23 nephrologist speaking in support of Satellite. (Spells
24 name)

1 MR. HYLAK-REINHOLTZ: Joseph Hylak-Reinholtz,
2 legal counsel to Satellite. (Spells name) And I did that
3 to myself voluntarily.

4 (Laughter)

5 CHAIRMAN GALASSIE: Thank you, and welcome
6 back.

7 MR. CLARK: Jeff Clark, legal counsel for
8 Satellite, Clarke with no E.

9 CHAIRMAN GALASSIE: Thank you, and now if you
10 could be sworn in, please.

11 (Oath given.)

12 CHAIRMAN GALASSIE: Thank you very much.
13 Staff report, please.

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

15 The applicants are proposing the establishment
16 of a 16-station ESRD facility, located in 7,000 gross
17 square feet of leased space in Glenview, Illinois. The
18 anticipated cost of the project is approximately \$4.1
19 million. The anticipated project completion date is August
20 31st, 2012. No public hearing was requested. Letters of
21 support and opposition were received by the State Board
22 Staff.

23 There currently is an excess of 25 stations in
24 the HSA 7 ESRD Planning Area.

1 CHAIRMAN GALASSIE: Thank you very much.
2 Comments for the Board specific to the
3 application, please?

4 MR. BURDEN: The transfer agreement, is it
5 with Glenbrook? I'm talking about the Transfer Agreement,
6 North Shore University Health Systems and Glenbrook
7 Hospital. I live in Glenview, so I'm interested in --

8 (Inaudible)

9 CHAIRMAN GALASSIE: I've been asked to stop.
10 Again, it appears we need a third microphone at that table.
11 When you're speaking, please speak into that microphone.

12 Again, any specific comments to the
13 application for the Board?

14 MR. BURDEN: Sort of. I mean, I asked a
15 specific question. North Shore University Health System
16 comprises four hospitals, of which I'm very familiar,
17 having been on the staff of them, but I specifically asked
18 about the institution in my community, affiliated with this
19 proposed applicant, and your answer was, I think, yes. No?

20 MR. HYLAK-REINHOLTZ: We did provide it in the
21 application. I will find the page number for you.

22 MR. BURDEN: It's on page 7. It doesn't state
23 the institution, just a system. It's not a big point.

24 MS. OLSON: I have a specific question .

1 CHAIRMAN GALASSIE: Yes.

2 MS. OLSON: Could somebody at the table
3 address for me your status? Are you non-profit, are you an
4 LLC?

5 MR. BRANSON: Satellite Healthcare --

6 MS. OLSON: I'm not sure it makes a lot of
7 difference. What makes a difference to me is if you are
8 misrepresenting yourself as a non-profit when you are not.

9 MR. BRANSON: Satellite Healthcare is a
10 California not-for-profit corporation. Satellite Dialysis
11 of Glenview, LLC is a wholly-owned subsidiary of SATELLITE
12 Healthcare.

13 CHAIRMAN GALASSIE: Which also is a
14 not-for-profit?

15 MR. BRANSON: It's an LLC. So, by definition,
16 it is not a not-for-profit. It's a subsidiary of a
17 not-for-profit entity.

18 MS. OLSON: So the Glenview site would be
19 for-profit?

20 MR. BRANSON: Well, If we end up with some
21 additional partners at that center, which we do not have at
22 this time, a portion of that entity is for-profit, but all
23 of the operating results of all of our LLC ultimately go to
24 the parent company, which is a not-for-profit organization.

1 MS. OLSON: Okay. Thank you. I just wanted
2 to be clear. I don't want to be misrepresented. That's
3 all I'm asking you.

4 MR. HYLAK-REINHOLTZ: I just want to be clear
5 that everywhere in the application we are very explicit to
6 point out that Satellite Healthcare is the 501(c) entity
7 and that the LLC is a Delaware LLC. Despite the comments
8 made earlier, everywhere in our application, we do clearly
9 state that it's an LLC entity.

10 MS. OLSON: And I do see that in the
11 application.

12 MR. CARVALHO: Mr. Chairman.

13 MR. BRANSON: In many geographic areas, we
14 have physician partners or colleagues that we would like to
15 partner up with, and as presented earlier in today's
16 testimony with other applicants, there is some reasons why
17 that produces some better alignment. We do not have that
18 situation presently with this particular dialysis center.

19 CHAIRMAN GALASSIE: I believe Mr. Carvalho
20 has a question and then Member Sewell.

21 MR. CARVALHO: Yeah. I just wanted to follow
22 up on this issue of not-for-profit or for-profit, as well,
23 and let me do it by analogy. In the nursing home field, we
24 have had applicants where they say they're not-profit, but

1 if you inquire, "Who founded you, is it some charity, is it
2 a religious organization" whatever, it turns out it was a
3 coalition of for-profit businesses that chose, for whatever
4 reason, that the ownership of one of the entities in a
5 not-for-profit status was beneficial to the feeding on this
6 whole profit center by all of the for-profit companies, and
7 so we've seen that in the nursing home situation. I'm
8 trying to figure out what exactly is the status? You are a
9 non-profit entity. Was it formed by a charitable entity?
10 Does it have a charitable impulse? What is the origins of
11 the not-for-profit entity that's at the heart of this?

12 MR. BRANSON: I can answer that specifically.
13 Satellite has been in operation for almost 40 years as a
14 non-profit organization. It was established by a
15 nephrologist from Stanford University, Norman Coplon, as an
16 alternative for hospital-based dialysis programs. So, the
17 original thrust was for the organization to be a
18 not-for-profit, because it would better serve the community
19 and the community of the ESRD patients, and it has remained
20 that way ever since.

21 MR. SEWELL: I'd like to hear you address how
22 your care might be different from some other ESRD
23 providers. We've heard some testimony that a higher
24 percentage of your patients are able to operate more

1 independently because you have more of an emphasis on what,
2 home dialysis? I want to understand that a little bit.

3 MS. SCHILLEL: May I take that question? I'm
4 Chief Medical Officer. I'm speaking because I was first
5 trained in Germany. I'm German, and I'm a nephrologist who
6 has worked in this area here. I retrained at Evanston
7 Hospital and then did my fellowship at the University of
8 Chicago. I've been in private practice in the United
9 States. And the reason I bring this up is to tell you that
10 I've seen the way dialysis can be delivered in many
11 different shapes.

12 We at Satellite pride ourselves that what we
13 have tried to reinvent over the last eight years is what
14 dialysis meant to be in the first place. Dialysis has been
15 available in the U.S. since the early 60's and celebrated
16 50 years of being able to provide dialysis last year, and
17 it was meant to really provide patients with a full
18 rehabilitated life. We never intended to treat patients to
19 just live for dialysis but rather to have a functioning
20 life. That may have been a little bit under appreciated
21 and the focus was a little bit lacking over the last 20
22 years.

23 At Satellite, we have a dedicated effort to
24 see that it is possible to have patients in the U.S. also

1 to undergo home dialysis, which allow for more independent
2 lifestyle and, therefore, more functioning lifestyle, and
3 we have achieved this through a dedicated effort through
4 education, through freestanding, home dialysis facilities,
5 which is the wellbound principle, which you've heard
6 mentioned in testimony before, which really bases on
7 education, educating the patient early on, and providing
8 the patients the full spectrum of the options a patient
9 might have. We talk in those discussions about what
10 happens if you do nothing, what happens if transplantation
11 is to occur, that there are two different home modalities,
12 peritoneal and home hemodialysis, what the implications are
13 for the patient, what the hardship is, what the benefits
14 are, that there are variations of doing in-center dialysis.

15 And I can go on with my testimony, or I can
16 bring this up front right now. But basically tell you that
17 with this approach, we have achieved that 23 percent of our
18 population is currently undergoing home therapies. That is
19 three times as much as the national standard. We have, out
20 of these patients, 4 percent on home hemodialysis and the
21 other -- out of all of our patients on home dialysis, 90
22 percent on peritoneal dialysis. That leaves 77 percent
23 in-center. Of those, 80 percent undergo more frequent
24 dialysis, meaning that due to their personal or clinical

1 needs, they undergo more than three times a week standard,
2 conventional treatments. We also have a fast-growing
3 nocturnal program, which at this stage -- which was only
4 started two years ago -- now comprises 2 percent of our
5 patients.

6 I would like the Board to be aware, because
7 I've heard a lot of testimony about needs of four shifts,
8 yes or no. We talk about the statistics of -- the USRDS
9 clearly state this, that the fastest-growing segment of the
10 patients that need dialysis in the U.S. is the patient
11 older than 75 years old. However, because the population
12 between 45 and 65 is bigger, that's actually the in-center
13 patients. This is the majority of patients coming in.
14 These are patients who are clearly still in their full mind
15 of working. These are patients who are looking forward to
16 a happy and active retirement plan, which is often
17 curtailed by having to go on dialysis. This is also the
18 population, as we can show you with our own numbers, who
19 does prefer to go on home therapy and, therefore, we were
20 very successful to do this.

21 CHAIRMAN GALASSIE: Thank you, Doctor. And
22 we've gotten into a lot of questions before we actually
23 asked you for comments. So, if some of the questions are
24 already answered through comments, so be it.

1 MR. HYLAK-REINHOLTZ: If I could respond to
2 Dr. Burden.

3 Dr. Burden, on page 168 of the application is
4 our Patient Transfer Agreement with North Shore University
5 Health System. It names Glenbrook Hospital, Skokie
6 Hospital, Highland Park Hospital, and Evanston Hospital as
7 the systems that we can refer patients to as necessary.

8 MR. BURDEN: That's North Shore. I was
9 specifically interested in the hospital closest to where
10 you're proposing this, which is located just about four
11 blocks from my home.

12 CHAIRMAN GALASSIE: Thank you very much.
13 Comments for the Board specific to the
14 application at this point, please.

15 Hearing none, does the Board have any other
16 questions for the applicants?

17 MR. HYLAK-REINHOLTZ: They have some prepared
18 remarks, if the Board would listen to them.

19 CHAIRMAN GALASSIE: You have that
20 opportunity.

21 MR. BRANSON: Absolutely. For the sake of
22 brevity and since some of the questions have already been
23 answered, I'll try to tailor my prepared remarks. I think
24 you heard earlier that we own and operate a home dialysis

1 center of excellence in Skokie, Illinois, and we've been
2 doing that since 2007. However, this is the first time
3 that we appear to the CON application process, because we
4 do not currently operate any entity of renal disease
5 in-center facilities in Illinois. So, we're looking
6 forward to discussing our proposal with you here and
7 answering any questions pertaining to our application.

8 But I feel like we should tell you a little
9 bit about Satellite Healthcare, other than the comments
10 that I made earlier here. We operate 30 in-center dialysis
11 programs in two states, California and Texas. We also
12 operate a number of home dialysis training and patient
13 education centers through our affiliate, Wellbound, and
14 those programs operate in four other states, including here
15 in Illinois, and through these Wellbound Centers of
16 Excellence, we're able to offer patients with chronic
17 kidney disease more comprehensive care, better treatment
18 choices, and more convenience. In addition, to the
19 traditional dialysis services, we have a robust Wellbound
20 education program that helps patients really take the next
21 step, what the doctor was referring to in terms of
22 empowering them and their families to really lead
23 healthier, longer and, frankly, more near normal lives, and
24 it's based on that success of the program here in Skokie

1 that we and our affiliated physicians here would like to
2 extend that service offering in the form of an in-center
3 dialysis program.

4 We determined there was a need to develop this
5 program in the northwest suburbs, and we found an ideal
6 location in Health Service Area 7 that was near our
7 Wellbound center and, frankly, close proximity to the
8 patients and their physicians. And what we're trying to do in
9 this application is complement the services that are being
10 performed currently in Skokie and address some of the
11 methods of care and scheduling times that are not currently
12 available in the area. And so, concurring with our
13 physician partners, we thought that a new approach to
14 dialysis care was needed in this area.

15 So, we're here today to ask for your approval
16 and the opportunity to serve dialysis patients in Illinois,
17 using our national-recognized and what I characterize as
18 personalized approach to dialysis care. So, we're asking
19 for this approval primarily for three important reasons,
20 equally important reasons. One is that the facility itself
21 is going to address and ensure a high quality dialysis
22 program in the proposed area. In general, this area has
23 had a steady increase of elderly patient population, as
24 well as the ESRD population. Opening a new center in this

1 area is going to greatly improve dialysis care, or at least
2 access to care, especially the patients that have to
3 dialyze three times a week. Our proposed center will also
4 reduce travel times, which is critically important, as you
5 heard earlier, because ESRD patients typically have limited
6 incomes and greater constraints on their ability to travel.
7 The closer facility means less patient stress related to
8 transportation and more compliance with dialysis treatment
9 regimens, resulting in a better quality of life and
10 improved clinical outcome.

11 We also believe dialysis patients should have
12 more than one available option when it comes time to select
13 a dialysis provider that meets their needs, and I think you
14 heard that earlier from some of the patients in the
15 community. At this moment, dialysis patients living in our
16 proposed service area really have limited alternative
17 choices, because the market is controlled by Fresenius and
18 a limited number of other organizations. These
19 organizations operate typically with a different corporate
20 philosophy than Satellite. But, more importantly, they do
21 not offer the full continuum of dialysis services that will
22 be available through our combined, proposed in-center
23 program, coupled with our existing Wellbound education and
24 home dialysis training.

1 We understand the Board's approach to
2 determine whether a proposed facility is necessary is
3 largely based on a two-step analysis. They consider the
4 Board's needs estimates, as well as existing capacity of
5 nearby providers. However, we also believe it's equally
6 important to examine the type and quality and availability
7 and treatment options at those existing facilities to
8 determine whether a proposed facility is needed. This
9 comparison allows the Board to identify unique services
10 when compared to existing providers. And our proposed
11 facility will improve access to care, because Satellite
12 dialysis of Glenview will offer new treatment and
13 scheduling options that are not currently available or are
14 limited in availability.

15 Secondly, the patients served at Satellite
16 Dialysis at Glenview will benefit from our patient-centered
17 care model, where each patient receives individual dialysis
18 treatment that results in the best and superior care. Our
19 facility will offer dialysis patients greater flexibility
20 and choice when the time comes to obtain dialysis
21 treatments. In addition to the three shifts per day model,
22 our Glenview facility plans to offer evening dialysis
23 shifts to accommodate dialysis patients who have jobs
24 during the day, and, more importantly, we also plan to

1 provide nocturnal dialysis for people who would benefit
2 from longer treatments. This is simply a continuation of
3 alternative therapies from patients that Dr. Schillel
4 talked about earlier. We strongly believe that one size
5 does not fit all.

6 Satellite, in partnership with our affiliate,
7 Wellbound, will also offer dialysis patients the most
8 comprehensive program for wellness education and dialysis
9 care. By pairing an in-center dialysis program with our
10 existing Wellbound center, we believe we can provide
11 patients with more continuity and more comprehensive care.
12 This integrated and comprehensive service offering makes
13 Satellite truly unique when compared to the existing
14 dialysis facilities located in our proposed service areas.
15 The proposed facility will greatly increase patients'
16 chances of obtaining dialysis treatment for the preferred
17 time of day, as well as also increase their ability to
18 select the most appropriate treatment method and provide
19 for more continuity of care for home dialysis patients.

20 Third, Satellite Healthcare is a
21 not-for-profit corporation, has no shareholders and,
22 therefore, answers to the communities it serves, and
23 particularly the community of ESRD patients. We require
24 each of our affiliates and subsidiaries, even those formed

1 as Limited Liability Corporations, to follow Satellite
2 Healthcare's policies and procedures when addressing
3 patients' assistance. When Satellite was founded in 1973,
4 we purposely chose to organize as a non-profit
5 organization, and we have operated that way for 40 years.

6 So, in conclusion, we ask for your support
7 today. We're confident that our proposed facility has
8 significant merit, as Satellite offers a unique choice to
9 dialysis that is not matched by any of our competitors.
10 Our aim is to fully benefit dialysis patients in the
11 northwest suburbs and the community as a whole by offering
12 new treatment options and greater flexibility.

13 Once again, thank you.

14 CHAIRMAN GALASSIE: We appreciate your
15 comments.

16 Any other questions from Board members?

17 MR. HILGENBRINK: Mr. Chairman.

18 Could someone address -- there's a standard
19 for the reasonableness of project costs. Could that be
20 addressed? It exceeds that standard.

21 MR. BRANSON: Yes. I believe we got comments
22 back that we were over an aggregate by about \$12 per square
23 foot, and that's partitioned in a couple different areas.
24 I think -- in taking a look at those numbers, I think we

1 can make it within the stated parameters set forth by this
2 Board here. We have a large contingency in our budget
3 proposal, and I don't believe any of our numbers have
4 tenant improvement credits that we're anticipating under
5 the lease, which run about \$25 to \$30 per square foot. So
6 that should not be a barrier.

7 MR. HILGENBRINK: Thank you.

8 CHAIRMAN GALASSIE: So you would be on record
9 to agree to that?

10 MR. BRANSON: We would.

11 CHAIRMAN GALASSIE: So noted.

12 MR. HAYES: Mr. Chairman.

13 CHAIRMAN GALASSIE: Yes, Mr. Hayes.

14 MR. HAYES: You know, I'd like to take an
15 opportunity to be able to ask some questions, because I
16 have you up here now with the medical staff as well as your
17 attorneys and your administrators. You know, what I'm
18 seeing from the information that we have run, that we have
19 read, and also Dr. Burden described an article that
20 basically discussed the idea of longer term -- more hours
21 in dialysis, and I understand your idea of having home
22 dialysis, and I think we all support that, and I understand
23 the four shift and nocturnal shift even can be very
24 effective. But there is a major difference between the

1 United States and Europe about the amount of hours on
2 dialysis and the frequency. Could you go into that a
3 little bit more? I think it's very important for the Board
4 to understand that.

5 MS. SCHILLEL: Yes. I think there is a clear
6 understanding now that more frequent dialysis is
7 beneficial. There was recent data referred to in a New
8 England Journal, just recently published on September 22nd,
9 indicating that after the long interval when patients are
10 not dialyzed, which is usually Friday, Saturday and Sunday,
11 or Sunday and Monday, depending on which cycle of shift
12 you're on -- Monday, Wednesday and Friday or Tuesday,
13 Thursday, Saturday -- there is a high -- much increase, 36
14 percent increase, of cardiovascular mortality, and 22
15 percent increase (inaudible) mortality within the two-day
16 interval. There's also good data to show that because we
17 have measured the adequacy of the appropriateness of how
18 well therapy is done by what you referred to before, URR
19 and Kt/V, and there is increasing evidence now to see that,
20 obviously, the quality of life and the fluid control on
21 dialysis the cardiovascular probabilities needs to be in
22 our front focus, and this is currently addressed with these
23 variations of going on from the one-size-fits-all.

24 This is what I refer to that, in fact, an

1 individualized approach -- clearly there will be patients
2 who may not tolerate, who may not want more than three
3 times a week treatments and, frankly, when I came to this
4 country, I was always told U.S. patients don't want home
5 dialysis. That was, frankly, not my experience in private
6 practice, nor is it now in in-center. An educated patient
7 will embrace, will make their decision, and, in fact,
8 nephrology world is one of those few specialties in
9 medicine who really didn't do full informed consent. We
10 are not required to do full informed consent in terms of
11 what differences might be happening with the various
12 treatments.

13 So, we strongly -- there is clearly a trend to
14 changing this, and I think from the current, 93 percent of
15 our patients are dialyzed in-center dialysis in the U.S.
16 and only 7 percent are on home therapies, mainly P.D. I
17 think there is close to 2 percent in the U.S. on home
18 hemodialysis. I expect that distribution to change over
19 the years to come.

20 MR. HAYES: Does the other doctor want to say
21 something?

22 MR. NASH: Hi. Kevin Nash. I just want to
23 add a little to what Brigitte said. I think all of us, I
24 think, would agree, the current dialysis situation is not

1 acceptable. I don't think that's an indictment of
2 Fresenius or DaVita or Satellite or anyone. I think it's
3 just -- it's time that we try and show some more
4 flexibility and some more innovation, and I think one of
5 the things that does seem to make the most difference is
6 increased dialysis, or at least tailoring the dialysis for
7 the patient. Every week I probably have to tell someone
8 they're going to have to start dialysis, and I go through
9 the options, and people sometimes can't get past this, "You
10 mean, I'm locked into this six a.m., Monday, Wednesday,
11 Friday time?" or "I can't be there at four o'clock." And I
12 think one of the things we're hoping with Satellite is
13 that -- and what we've seen, at least, in the Wellbound
14 unit is we will provide more opportunities for patients to
15 not -- as one patient put it to me, he said, "I don't, you
16 know, live to dialyze. I'm dialyzing to live. I don't
17 want to have my whole life, my family's life, everything
18 worked around this schedule."

19 I think Mr. Sewell earlier asked why more
20 people aren't on home dialysis. I think it's
21 multi-factorial, but some of it is the current system, the
22 units that do both in the same unit. It's a little bit of
23 robbing-Peter-to-pay-Paul kind of situation. Where if
24 you're putting a patient on hemo, you're simply putting

1 them on peritoneal and taking them out of the hemo
2 population. I've been very successful dealing with the
3 Wellbound, which is a separate entity; in other words, a
4 home dialysis corporation, part of Satellite, that doesn't
5 do anything else, but there's not a conflict of interest
6 necessarily, that you're taking away from, and I think
7 that's been very successful.

8 But the other situation is the education. A
9 lot of patients who could do home dialysis wind up not
10 doing it because they're afraid or they don't learn about
11 it, and we've been very impressed with Satellite's CKD or
12 Chronic Kidney Disease program where patients have their
13 questions answered and they ultimately choose what option
14 is best for them. Obviously, most people are not going to
15 do home therapy, but, honestly, I would, and I think very
16 few nephrologists -- maybe none -- would do three times a
17 week, set scheduled dialysis. Some people would do
18 nocturnal, some people would do it at home, peritoneal, and
19 we want our patients to have the same options that we have,
20 without having to have medical school or do your own
21 machine or anything like that. I believe that Satellite
22 offers that.

23 CHAIRMAN GALASSIE: Thank you.

24 MR. BRANSON: One brief, supplemental comment.

1 I'll defer to the doctors on this, but we're at an
2 interesting point in history with respect to dialysis
3 services. I think when you talk about quality of care, you
4 will hear a lot of language about these bio-clinical
5 markers, Kt/V, URR, hemoglobin rates, and so on, and I
6 think for the most part, the dialysis industry has been
7 very good at achieving those outcomes. I think what we're
8 trying to do is push the barrier farther. I think there is
9 some evidence, strong evidence, that those clinical markers
10 only account for a small minority of hospitalization,
11 mortality rate for patients, somewhere in the neighborhood
12 of 15 percent.

13 The healthcare system is broken and in the
14 dialysis system there are some broken pieces as well. So
15 we're pushing for a different type of dialysis program, one
16 that involves alternative therapies that are tailored to
17 individual patients and, frankly, a lot more care
18 coordination.

19 CHAIRMAN GALASSIE: Excuse me. I'm sorry.
20 Can I again ask the audience, if you're going to have
21 conversations, would you please take it out in the hallway.
22 Thank you.

23 I didn't mean to interrupt you, but thank you
24 very much.

1 MR. HAYES: You know, my question was very
2 focused, and this is from a layman, coming from. Over in
3 Europe, many dialysis patients have dialysis more than
4 three times a week and they may have it for up to six or
5 eight hours. Is that correct?

6 MS. SCHILLEL: Yes, that's absolutely correct,
7 and, in fact, that was our guidance of starting the
8 nocturnal program as well. There's a very famous
9 nephrologist, and every nephrologist knows, in France, and
10 this is where they have been doing this for the last 20
11 years, and this is where the best mortality and survival
12 rates are.

13 MR. HAYES: So, why hasn't that -- why hasn't
14 that become common in the United States, because we have --
15 on our Board here, we hear very one-size-fits-all.

16 MS. SCHILLEL: It is operationally -- and I
17 will attest to that. I've assisted with the nocturnal
18 programs that were opening. It's operationally a difficult
19 task. You need to find the dialysis professionals. The
20 nurses are not used to working nights. That is a shift
21 of -- you know, if somebody works in dialysis, they are
22 used to daytime work hours. It's very hard to find
23 competent staff for night shifts, and you need competent
24 skilled staff in night shift. That is one issue.

1 The other issue is that, really, there wasn't
2 a thinking. It's just harder to implement. The other
3 issue is really that one of our questions was really if
4 patient and physicians would embrace it, and I think we
5 were pleasantly surprised that this was beyond their
6 expectations. In the United States, there was an
7 overwhelming feeling that short and quick and efficient
8 dialysis is what the patients want, and we have a lot of
9 trials that indicated that there was no difference, if you
10 changed the Kt/V to a little more, but yet now we're
11 focusing on is there, in fact, another survey marker which
12 is more important to look at, and time appears to be one of
13 those emerging factors.

14 MR. HAYES: Now, over in Europe do they
15 basically -- most dialysis centers are hospital-based or
16 clinic-based.

17 MS. SCHILLEL: I need to say that I left
18 Germany 20 years ago, so I can tell you I have been back,
19 but some are hospital, patient -- some are hospital-based,
20 but not all. I cannot give you a percentage. Many
21 patients are dialyzed in beds in the hospitals, but they
22 are freestanding units, clearly. That's where I started
23 dialysis in Munich. There are a number of variations of
24 why this is done differently, and it would probably keep us

1 here for quite some time, but there is certainly the same
2 principle as the freestanding dialysis units, is the
3 majority. When I was in Germany, certainly that was the
4 predominant way to deliver dialysis.

5 CHAIRMAN GALASSIE: John, if I may, it's --

6 MR. HAYES: Freestanding.

7 CHAIRMAN GALASSIE: It's twenty to one, and
8 this clearly is extremely helpful and informative and is
9 screaming for us to have our dialysis retreat, which I am
10 sure after these two days we will be scheduling soon. I
11 think we are at a point where we can move this to a vote.

12 If I may, I would propose a motion to approve
13 Project 11-061 for the establishment of a 16-station ESRD
14 facility in Glenview, Illinois.

15 MR. HILGENBRINK: So moved.

16 MS. OLSON: Second.

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

19 MR. DART: Motion made by Mr. Hilgenbrink,
20 seconded by Ms. Olson.

21 Dr. Burden?

22 MR. BURDEN: This is a very interesting
23 application. I'm looking at -- you are, unfortunately,
24 batting 4th, which is the clean-up spot. You're expected

1 to hit a home run and, indeed, you know full well by now
2 that we've already passed several prior applicants. So, we
3 now have a significant excess of beds in HSA 7. Everybody
4 who comes in front of us with an application feels they are
5 unique and remarkably unique and we can't turn you down,
6 you know, that kind of attitude, which I suspect is part of
7 marketing salesmanship and preparation. But I'm buying
8 into it, even though I'm against the thought that I might
9 be criticized for voting pro for something where we already
10 have significant -- according to our HSA finders we have
11 areas for people to get dialysis. I got to vote for you.
12 I would hope when we see the results that you bring to the
13 table that you apparently can compete successfully with the
14 huge monopolies that occur in our town and I have made the
15 right choice.

16 I vote yes.

17 MR. DART: Mr. Eaker?

18 MR. EAKER: I also have conflicting feelings
19 about the vote and the difference between need and what
20 you're offering. I side on the side of better access to
21 care for the patients. I'll vote yes.

22 MR. DART: Justice Greiman?

23 MR. GREIMAN: I'll vote yes also.

24 MR. DART: Mr. Hayes?

1 MR. HAYES: I vote yes, because I feel that
2 this does offer alternatives, and that's very important.

3 MR. DART: Mr. Hilgenbrink?

4 MR. HILGENBRINK: I, too, am a strong
5 proponent of choice and access, and I vote yes.

6 MR. DART: Ms. Olson?

7 MS. OLSON: I vote yes for patient access and
8 patient choice.

9 MR. DART: Mr. Sewell?

10 MR. SEWELL: Yes.

11 MR. DART: Chairman Galassie?

12 CHAIRMAN GALASSIE: Chair votes yes.

13 MR. DART: Eight votes.

14 CHAIRMAN GALASSIE: Motion passes.

15 Congratulations. Thank you very much.

16 We are at a quarter 'til one, and we are going
17 to be recessing for lunch. We will try to be back here --
18 the plan will be to be back here at 1:30. We have six or
19 seven applications remaining:

20 (Lunch recess)

21 CHAIRMAN GALASSIE: I will call us back in
22 session from recess. Thank you for being timely.

23 And just a comment for the Board members. I
24 think we got a little out of sync earlier, and I take

1 responsibility as Chair. I think we're best to bring
2 public comment up, if any; from public comment bring up the
3 applicants; and after they're sworn in, let the applicants
4 give their comments, if any, to the Board, and then the
5 Board questions. I think it will just move better for all
6 of us. Thank you.

7 That having been said, Item No. 11-60. We do
8 have public comment. John Kniery. John, if you would just
9 introduce yourself. You don't have to be sworn in. This
10 is public comment.

11 MR. KNIERY: Thank you, Mr. Chairman. My name
12 is John Kniery (spells name).

13 As the public comment period ended 20 days
14 ago, we have been receiving support letters. I don't want
15 to read all the letters in. We received 18 additional
16 letters, in addition to the 57, but if I could go through a
17 few of them, and cut me off when you need me to.

18 CHAIRMAN GALASSIE: We'll give you two.

19 MR. KNIERY: Dr. Thomas Carver, "I write this
20 letter in wholehearted support for the approval of the
21 Certificate of Need requested for Dr. Randy Morris. I've
22 known Dr. Morris and have utilized his reproductive health
23 and fertility specialty services for my patient population
24 ever since. The success rates in achieving pregnancies for

1 my infertility patients is outstanding, especially those
2 requiring advance techniques such, as in vitro fertilization
3 and embryo transfer for achieving their pregnancy."

4 "Dr. Morris is compassionate and professional,
5 and I have nothing but high praise for him and his staff.
6 When the patients do come back to me, they do complain,
7 however, about the distance required in traveling for
8 specialized in vitro services and the inability of access
9 to these services on weekends and holidays and when these
10 facilities are closed, delaying their much anticipated
11 conceptions and increases the cost of involvement."

12 From Dr. Kenneth Sigel, and I'm just
13 paraphrasing. I'm trying not to read the entire letter.
14 "I have been referring infertility patients to Dr. Morris
15 for the last 15 years. My patients have been so satisfied
16 with his care and compassion. The only inconvenience has
17 been with the need to go downtown to Chicago for in vitro
18 fertilization. As menstrual cycle timing is a critical,
19 limiting factor in this therapy, a convenient, closer
20 location, one open on Saturday and Sundays, could greatly
21 benefit our patients in the far western suburbs."

22 CHAIRMAN GALASSIE: John, do you know what I
23 think would be productive, if I may? Give the Board a
24 sense of who is writing the letters. I think we can assume

1 the concept.

2 MR. KNIERY: Sure. We've been receiving
3 letters from referring physicians but also from his
4 patients, just to kind of tell their story and what they
5 went through, and I'll read one, and I can probably not go
6 on with the rest.

7 CHAIRMAN GALASSIE: Okay.

8 MR. KNIERY: "I've been a patient of
9 Dr. Morris" -- this is from Linda Remington. She signs it
10 "A proud mother of a five-month-old son." "I've been a
11 patient of Dr. Morris for nearly five years, and during
12 this time, I have found that he and his staff have been
13 consistently outstanding. Their professionalism and high
14 standards, accompanied by their warmth, kindness,
15 friendliness, have really made this whole in vitro
16 fertilization process much easier for my husband and me to
17 deal with and understand. I have a full -- having a full
18 service facility in Naperville would be extremely
19 beneficial to current and/or future patients. My husband
20 and I have had to travel to downtown Chicago numerous times
21 for the various procedures while working with Dr. Morris.
22 Overnight stays at nearby hospitals have quickly become too
23 costly for us, so we had options of long round-trip drives
24 whenever it was necessary. Traveling over an hour and a

1 half during a January snow storm, at 3:30 a.m., is not fun,
2 nor is traveling during the warmer months when road
3 construction and traffic is in full bloom. We have had to
4 do both several times, while also having to stay calm and
5 praying for success. A facility in Naperville would be
6 such a welcome stress reliever and would help patients
7 focus their thoughts and energy on the process about to
8 happen."

9 CHAIRMAN GALASSIE: Thank you. So as the
10 Board hears we have -- they had 18 letters of support come
11 in after the public comment period is closed. Thus,
12 reading the 18 letters wasn't appropriate, but we certainly
13 get the gist of the community physician support and their
14 community patient support.

15 Any other comments?

16 MR. KNIERY: That's it. Thank you.

17 CHAIRMAN GALASSIE: Thank you.

18 That is the close of public comment. We will
19 move forward to the applicant, those representing
20 Naperville Fertility Center, Application No. 11-060.

21 Good afternoon. If you would, please
22 introduce yourselves, spell your name to our Reporter, and
23 we'll have you sworn in.

24 MR. KNIERY: Again, thank you, Mr. Chairman

1 and the Staff, and the Board. My name is John Kniery with
2 Foley and Associates Certificate of Need consultant. To my
3 right is Dr. Randy Morris (spells name), representing the
4 applicant. To my left is Mr. Jay Scharer (spells name).
5 He's the CFO for the project. And to his left is Kelly
6 Schreihofner (spells name). She's with Proteus Group, the
7 Project Manager.

8 CHAIRMAN GALASSIE: Thank you.

9 (Oath given)

10 CHAIRMAN GALASSIE: Thank you.

11 Staff report, please.

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

13 The applicant proposes to establish a limited specialty
14 ASTC. The estimated cost of the project is approximately
15 \$6.9 million. The anticipated completion date is
16 September 30th, 2013. No public hearing was requested, and
17 the State Board Staff did receive letters of support and
18 opposition regarding this project. Thank you,
19 Mr. Chairman.

20 CHAIRMAN GALASSIE: Thank you.

21 Comments for the Board?

22 MR. KNIERY: Chairman Galassie and members of
23 the Board, I would like to thank the Staff for their
24 thorough and timely project review. I would like to have

1 Dr. Morris present the project, and I would preface this
2 presentation by saying you will notice by the very nature
3 of the project and how it varies from typical ASTC's
4 provides us with the rationale of how this project meets
5 and differs from the State's standards.

6 Dr. Morris.

7 MR. MORRIS: Good afternoon. My name is
8 Dr. Randy Morris. Thank you for this opportunity to
9 present the Naperville Fertility Center project for your
10 consideration.

11 By training, I am a Board-certified
12 reproductive endocrinologist. To reach this level, a
13 physician must complete a four-year residency program in
14 obstetrics and gynecology. This is then followed by a two
15 to three-year fellowship or sub-specialty training. Board
16 certification is a combination of written and oral
17 examinations. Maintenance of certification is required
18 annually in Illinois. I have just completed my
19 requirements to recertify for 2012.

20 A reproductive endocrinologist is a specialist
21 in infertility, fertility preservation, recurrent
22 miscarriage, and female reproductive surgery. After
23 completing my fellowship in California in 1994, I returned
24 to my home state of Illinois to practice. Shortly

1 thereafter, I began my own practice in Naperville, where I
2 have been ever since.

3 Our goal with this project is not to simply
4 replicate what has been done elsewhere, but to create a
5 first-class facility in Illinois that will become a source
6 of pride for the entire state. Unwanted childlessness is
7 unique among medical diseases, and that creates a
8 tremendous amount of emotional suffering to those affected.
9 Studies of infertile couples find an extremely high rate of
10 depression, anger, and anxiety. Only cancer patients show
11 similar levels of suffering. Two-thirds of women report
12 making sacrifices in order to pursue the dream of a child,
13 including putting their career on hold or declining a
14 promotion.

15 In vitro fertilization has emerged in the last
16 decade as the most successful treatment of infertility
17 available. Studies have shown that although expensive, the
18 cost per child is actually lower with in vitro
19 fertilization, because the pregnancy rates are so much
20 higher than with other less expensive forms of treatment.
21 However, in vitro fertilization is a very
22 technically-demanding procedure. Difficulties in
23 performing in vitro fertilization have resulted in
24 differences in the pregnancy rates between programs of

1 threefold or more. In recent years, it has become
2 well-known that the in vitro facility itself is of
3 paramount importance in establishing and maintaining the
4 highest probability for pregnancy. As the field has
5 developed, old paradigms are swept away. It is no longer
6 the standard of care to perform in vitro procedures in the
7 local hospital operating room or doctor's office or
8 outpatient surgical center.

9 An IVS center must be constructed from the
10 ground up, with one purpose: To protect and enhance the
11 viability of developing embryos. Embryos are constantly
12 being assaulted from a variety of sources: Particle board
13 and other wood panels that release formaldehyde; PVC
14 flooring materials and carpets release a harmful group of
15 chemicals into the air, known as volatile organic
16 compounds, or VOC's, which have been shown to interfere
17 with embryo development; paints and commonly used adhesives
18 also release VOC's. The list goes on.

19 Since 1997, there have been published reports
20 of in vitro pregnancy rates plummeting in response to, for
21 example, remodeling occurring elsewhere in the building or
22 a surgery center that changes their cleaning service and
23 with it the use ammonia-based cleaning products and
24 aerosols. It is simply impossible to move into an existing

1 hospital or surgery center and hope to have any control
2 over the myriad variables that cause the destruction of
3 eggs, sperm, and embryos. In the letters you received, you
4 can see that this fact is strongly supported by the most
5 knowledgeable experts in our field, including university
6 department chairmen, directors of infertility divisions,
7 and current and past presidents of our national and
8 international professional fertility societies.

9 A growing portion of the field of reproductive
10 technology is the area of preservation. Young men and
11 women, who have been diagnosed with cancer and about to
12 undergo treatment with chemotherapy and more radiation, are
13 at significant risk for becoming sterile. Using the same
14 technologies that we use to treat infertile couples, we
15 can extract eggs, sperm and embryos and cryo preserve them
16 for future use. This allows these men and women to
17 preserve their fertility, even if it is destroyed by their
18 cancer treatment. This is especially important for the
19 pediatric population.

20 The challenge in helping fertility patients is
21 two-fold. Very often fertility preservation procedures
22 will need to be performed on an emergency basis, so as not
23 to delay the start of cancer treatment. Secondly, these
24 patients have more difficulty than the average patient for

1 traveling longer distances. Both Edward Hospital and
2 Naperville and Central DuPage Hospital in Winfield have
3 recently expanded their oncology programs. However, there
4 are no dedicated fertility preservation centers in the
5 western suburbs of Illinois. It is anticipated that this
6 new fertility center would serve as a convenient fertility
7 preservation center for these and other oncology programs
8 in the western suburbs.

9 I'd like to specifically address the square
10 footage concerns that were brought up by Staff. On initial
11 review, it would appear that this project is larger than
12 State standards. However, there are two important issues
13 to understand here. First, fertility is a private matter
14 for our patients. Maintaining their privacy was an
15 important feature in our design. For this reason, private
16 admit and recovery rooms will be utilized, instead of an
17 open area in which the private, sometimes embarrassing,
18 conversations can be overheard. The relatively short
19 duration of each procedure, as well as the large volume of
20 procedures that can occur in a single day, dictate the need
21 for five recovery bays instead of four. The need for
22 private rooms requires an increase above the State
23 requirement for recovery bays, to allow for clearances
24 within the room. This additional space also increases the

1 amount of circulation space, storage space, et cetera,
2 within the recovery area, all factoring into the amounts
3 above the State standards.

4 The majority of the overages about the State
5 requirements are due to the nature of the facility and it's
6 procedures. The very types of procedures and quicker
7 turnover rate require a larger amount of equipment to be
8 stored within the procedure room itself. In addition to
9 that, there are also requirements for specialty lab spaces
10 that must be either directly adjacent to or nearby the
11 procedure area. These additions, as well as the privacy
12 concern noted previously, coupled with the additional
13 circulation space required for these spaces, quickly make
14 up all of the overages above the State requirements.

15 Secondly, equipment cost. The surgical suite
16 itself will be supplied with the typical equipment that
17 might be found in any hospital or surgical center that
18 performs advanced gynecological procedures. It is the
19 associated laboratory equipment, such as incubators,
20 high-powered microscopes with robotic controls for
21 micro-manipulation, fume hoods, sperm analysis and
22 cryopreservation chambers, that result in the overall
23 higher cost. It should be noted that without this lab
24 equipment and furnishings, this criteria would, in fact, be

1 met.

2 I have met with other providers in the area,
3 and a formal agreement cannot be reached either because of
4 lack of interest or lack of space or willingness to put
5 forth the resources to deliver a similar ASTC package as
6 being proposed. As previously mentioned, the specific
7 application before you is unique and not readily available
8 in the service area throughout the state. Due to the
9 physical environmental controls that have to be met with
10 such a project, existing space is not usable for this
11 purpose without a significant cost in investment.

12 I've worked hard over the last 17 years and
13 have established a successful practice with an existing
14 patient base. This project is to make their treatment more
15 convenient and improve the success rate.

16 I would like to thank the Board and Staff for
17 their consideration for this project. I would like to note
18 again that this project did not meet with any serious
19 opposition, as no public hearing was requested. At this
20 time, we'd be more than happy to answer any questions that
21 you may have.

22 CHAIRMAN GALASSIE: Thank you, Doctor.

23 Questions by Board members, please?

24 MR. BURDEN: Doctor, you mentioned that you

1 have an annual CME review or request for annual CME? So
2 what sub-specialty requires such an extensive application
3 of that nature?

4 MR. MORRIS: For the last couple of years, all
5 of obstetrics and gynecology requires what's called ABC,
6 Annual Board Certification. So, it requires a review of
7 selected CME articles, answering of questions, which is now
8 actually done on line. Along with that, there is other
9 requirements for case review of patients that you have
10 seen, and there's certain modules that have to be completed
11 over time. But we have to do this now every year.

12 MR. BURDEN: Approximately how many people in
13 this Chicagoland community have confined their work to your
14 sub-specialty?

15 MR. MORRIS: Chicago area?

16 MR. BURDEN: Just how many? I'm just curious.

17 MR. MORRIS: Fifteen, twenty, maybe.

18 MR. HILGENBRINK: Doctor, what guidelines did
19 you follow for your -- you mentioned some green aspects
20 that you developed in the facility design. Did you adhere
21 to the Green Guide for Healthcare or any specific
22 guideline?

23 DR. MORRIS: I'd like to have Kelly answer
24 that question.

1 MS. SCHREIHOFFER: I'm the architect of record
2 for this project, so I can answer the question. We have --
3 we do keep in mind that the Green Health Guidelines,
4 absolutely. Are we following them to a T? No, but the
5 basic idea for this building and one of the main components
6 would be our wall system that we're going to look at is
7 kind of a new and innovative wall system, that for a
8 thinner wall, you get more R-value, which is going to help
9 reduce our construction time, our costs, and increase your
10 savings on the other end for HCAV and all of those. That's
11 just one of the examples that we're looking at and
12 including in this project.

13 MR. HILGENBRINK: The doctor mentioned some of
14 the chemicals that are developed in the construction
15 process. How are you addressing those issues, the paints
16 and the tile and chemicals?

17 MS. SCHREIHOFFER: We're using -- so, for the
18 procedure areas specifically, we're looking into
19 alternative materials to use for the finishes in there.
20 So, when you have paint in there, it off-gases VOC's, and
21 it's constant. It never goes away. So, we're looking at
22 harder surfaces, such as tile, Terrazzo for the floor,
23 something that is a harder surface, something that's not
24 going to off-gas those kinds of VOC's, which also has a

1 longer lifetime, which helps with our green aspect.

2 MR. HILGENBRINK: Did this have any impact on
3 your -- you're over your cost estimates and you mentioned
4 space as one of the issues, but did the construction
5 methods have an impact on your cost?

6 MS. SCHREIHOFER: It does, because it's not
7 your standard, have somebody come in lay down -- glue a
8 floor to the substrate. You have to come in and float the
9 floor. It's a longer process. It's a more expensive
10 material. Same with the tiles and walls.

11 MR. HILGENBRINK: Do you have an estimate, a
12 percentage or a dollar amount?

13 MS. SCHREIHOFER: It's accounted for in the
14 budget.

15 MR. HILGENBRINK: Specifically, can you pull
16 that out?

17 MS. SCHREIHOFER: I wouldn't have an answer
18 readily available.

19 MR. HILGENBRINK: So no specific amount?

20 MR. SCHREIHOFER: We didn't specifically
21 identify it or compare it.

22 CHAIRMAN GALASSIE: Thank you.

23 Mr. Carvalho.

24 MR. CARVALHO: Thank you. There were a couple

1 of aspects of this where I was confused. You're not
2 confusing them, I'm confused. Is this brand new space?

3 DR. MORRIS: Yes.

4 MR. CARVALHO: So, where it says the owner of
5 the building is Medical Properties, there isn't a building
6 yet? Or are you building out into existing space.

7 DR. MORRIS: No, it's going to be new
8 construction. The owner of the building will be Medical
9 Properties, and Naperville Fertility Center will lease that
10 space from Medical Properties.

11 MR. CARVALHO: So the building isn't built
12 yet, but when it is built, the owner of the building will
13 be --

14 MR. MORRIS: That's correct.

15 MR. CARVALHO: And who is Medical Properties?

16 MR. MORRIS: A corporation formed with my
17 wife, Jody Morris, and myself.

18 MR. CARVALHO: So, you're the owner of the
19 building in a different capacity, the operator of the
20 building in another capacity -- got it.

21 MR. MORRIS: That's correct.

22 MR. CARVALHO: Also, you're seeking a limited
23 specialty, and you describe all sorts of reasons why this
24 shouldn't be done with other procedures in hospitals and

1 described in your narrative -- so, would that take off the
2 table ever expanding this into a multi-specialty, because
3 you don't want other things occurring here other than this
4 one thing? The rationale for doing this is because you
5 would be doing this one thing. Is that something that you
6 want to limit, so that you're never doing other things in
7 this building? Otherwise, we're kind of going both ways on
8 that.

9 MR. MORRIS: Yes, with one exception, and that
10 is for urology. There are procedures that could be done
11 from the male perspective -- sperm extraction procedures --
12 that ultimately would be appropriate to do in a facility
13 such as this. So, if there was a multi-specialty request
14 in the future, it would only be to incorporate that
15 particular procedure.

16 MR. KNIERY: Let me make a correction, please.
17 A second surgical specialty but still limited to a limited
18 specialty. I don't believe -- and I hope I'm not speaking
19 out of turn, but I don't think we'd ever go before this
20 Board for a multi-specialty for this facility. We can add
21 one specialty, which would be urology, and still limit it
22 to a limited specialty.

23 MR. CONSTANTINO: You'd have to come back
24 before the Board and request it.

1 MR. KNIERY: That's correct, Mr. Constantino.

2 MR. CARVALHO: If part of the rationale for
3 approving this, notwithstanding there were not any other of
4 these ASTC's because of the uniqueness -- I just wanted to
5 make sure that we didn't get flipped the wrong way here and
6 have it be turned into a multi, if the whole rationale was
7 the uniqueness.

8 MR. MORRIS: We will not be adding any
9 dialysis chairs in the future.

10 (Laughter)

11 MR. CARVALHO: I don't think that's a
12 modality -- never mind.

13 Your application noted you were not
14 anticipating payor sources other than self-pay and insured.
15 Is that because Medicaid/Medicare do not cover this
16 procedure, or is it just not your interest?

17 MR. MORRIS: They do not cover it.

18 MR. CARVALHO: Okay. And then --

19 MS. OLSON: Medicare wouldn't probably cover
20 in vitro fertilization. Sorry.

21 MR. CARVALHO: You read the papers about the
22 grandmother --

23 (Laughter)

24 CHAIRMAN GALASSIE: Decorum, decorum. It's

1 getting late. Sugar is kicking in.

2 MR. CARVALHO: And this isn't a procedure
3 that's done on a charity-care basis.

4 MR. MORRIS: Well, yes and no. There may be
5 instances in which older women who have put off child
6 bearing or, for whatever reason, do want to attempt
7 pregnancy when they're older, it requires, in fact, some of
8 this advanced technology that we've been talking about this
9 morning. But, again, those would not be covered by
10 Medicare or Medicaid; it would be self-paid or insurer. In
11 the last year or so, we have begun to see some fertility
12 preservation patients. So, these are patients that were
13 referred to us that were in eminent need of cancer care,
14 and we were able, despite the sort of distance limitations,
15 to take care of them and are really hoping that we'll be
16 able to increase that sort of patient in the future.

17 MR. CARVALHO: Last question. You have --
18 you're providing some more services without an IVF lab at
19 900 North Michigan.

20 MR. MORRIS: Correct.

21 MR. CARVALHO: So after this is up and
22 running, you're going to be doing both, or are you
23 basically shifting your practice?

24 MR. MORRIS: Shifting.

1 MR. CARVALHO: What else is going on? Is that
2 a multi-specialty facility?

3 MR. MORRIS: 900? Yes it is.

4 MR. CARVALHO: That's the Bloomingdale
5 building?

6 MR. MORRIS: Yes it is.

7 MR. CARVALHO: So, your withdrawal from your
8 practice of that is not going to lead to that closure; it
9 goes on doing the other specialty?

10 MR. MORRIS: No. In fact, they're quite busy.
11 They recently received approval from this Board for
12 expansion, as well as creation of a new surgery center out
13 by Midway Airport. It is becoming somewhat problematic for
14 me, because of the increased volume. Recently, I'll tell
15 you that we've had to begin procedures as early as six a.m.
16 to accommodate the rest of their operating schedule, and as
17 the Board will notice, there was no objection from 900
18 North.

19 CHAIRMAN GALASSIE: Thank you.

20 Mr. Sewell?

21 MR. SEWELL: Are there other facilities of
22 this type in the metropolitan Chicago area?

23 MR. MORRIS: No, sir.

24 MR. SEWELL: So this would be the only one?

1 MR. MORRIS: Yes.

2 MR. SEWELL: On this question about payor
3 sources, have you given any thought to, or would you be
4 willing to provide some care to people who are not covered
5 by third-party insurance?

6 MR. MORRIS: There is an organization, a
7 national organization known as Fertile Hope, which is part
8 of the Lance Armstrong Live Strong program. It deals with
9 cancer patients. Programs that enroll with Fertile Hope
10 will agree to give procedures to cancer procedures for a
11 limited fee. That fee, however, does have to include
12 everything, including surgery center facility fees. We
13 have expressed interest in the past of joining that
14 organization, but we were unable to do so, because we don't
15 have control of the surgery center facility fee.

16 MR. BURDEN: Just briefly. You mentioned you
17 may expand to include urology. As you know, I am retired
18 in this activity, started well into my late career. So,
19 I've got too many gray hairs to talk about this, but I'm
20 asking. You might include, and do you include sperm
21 storage in your facility, or will you, besides just taking
22 the biopsy or aspiration? Is that essentially what you're
23 thinking about doing down the line, or will you be doing it
24 soon?

1 MR. MORRIS: For fertility preservation, we
2 hope to be able to to freeze eggs, sperm and embryos.
3 However, we do not anticipate becoming the long-term
4 storage facility for sperm. There are plenty of places
5 around where you can do that. So, we will do the freezing
6 and short-term storage but transfer it out.

7 CHAIRMAN GALASSIE: Other questions by Board
8 members?

9 (Pause)

10 CHAIRMAN GALASSIE: Hearing none, I will
11 propose a motion to approve Project No. 11-060 for
12 establishment of a limited specialty Ambulatory Surgical
13 Treatment Center located in Naperville, Illinois.

14 MS. OLSON: So moved.

15 MR. GREIMAN: Second.

16 CHAIRMAN GALASSIE: Moved and seconded. Roll
17 call, please.

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

20 Dr. Burden?

21 MR. BURDEN: Yes.

22 MR. DART: Mr. Eaker?

23 MR. EAKER: Yes.

24 MR. DART: Justice Greiman?

1 MR. GREIMAN: Yes.

2 MR. DART: Mr. Hayes?

3 MR. HAYES: Yes.

4 MR. DART: Mr. Hilgenbrink?

5 MR. HILGENBRINK: Yes.

6 MR. DART: Ms. Olson?

7 MS. OLSON: Dr. Morris, as a mother and a
8 grandmother, you had me at "hello". Yes.

9 MR. DART: Mr. Sewell?

10 MR. SEWELL: Yes.

11 MR. DART: Chairman Galassie?

12 CHAIRMAN GALASSIE: Yes.

13 MR. DART: Eight votes in the affirmative.

14 CHAIRMAN GALASSIE: Congratulations. Motion
15 passes. Thank you for your endeavor.

16 Moving on to Item No. 11-056, Sarah Culbertson
17 Memorial Hospital. There is no public comment. Applicant
18 members, will you please come to the table. We would ask
19 for you to introduce yourselves and spell your name for the
20 Recorder, and we will have you sworn.

21 MS. STAMBAUTH: Lynn Stambauth from Sarah D.
22 Culbertson Memorial Hospital. I'm the CEO there. (Spells
23 name)

24 MS. SORRELL: And my name is Molly Sorrell

1 (spells name).

2 (Oath given)

3 CHAIRMAN GALASSIE: Staff report, please.

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

5 The applicant proposes to discontinue its 29-bed skilled
6 nursing service on the campus of Sarah D. Culbertson
7 Memorial Hospital in Rushville, Illinois. There is no cost
8 to the project. The anticipated project completion date is
9 October 31st, 2011. No public hearing was requested.

10 Opposition letters were received by the State Board Staff.

11 Thank you, Mr. Chairman.

12 CHAIRMAN GALASSIE: Thank you. Comments for
13 the Board?

14 (Pause)

15 CHAIRMAN GALASSIE: Hearing none, questions
16 on the part of the Board members?

17 (Pause)

18 CHAIRMAN GALASSIE: Hearing none, I will
19 propose a motion to approve Project 11-056 for the
20 discontinuation of a 29-bed, Long-Term Care category of
21 service, located in Rushville, Illinois.

22 MR. SEWELL: So moved.

23 MR. BURDEN: Seconded.

24 CHAIRMAN GALASSIE: Moved and seconded. Roll

1 call, please.

2 MR. DART: Motion made by Mr. Sewell, seconded
3 by Dr. Burden.

4 Dr. Burden?

5 MR. BURDEN: Yes.

6 MR. DART: Mr. Eaker?

7 MR. EAKER: Yes.

8 MR. DART: Justice Greiman?

9 MR. GREIMAN: Yes.

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. SEWELL: Yes.

18 MR. DART: Chairman Galassie?

19 CHAIRMAN GALASSIE: Chairman votes yes.

20 Motion passes. Congratulations. Good luck.

21 Moving on to Item 11-064 Freeport Memorial

22 Hospital. There is no public comment.

23 Welcome, representative from Freeport Memorial

24 Hospital. Introduce yourself and spell your name, and

1 please be sworn in.

2 MS. CUTLER: Good afternoon. Nancy Cutler,
3 Vice-President of Patient Services and CEO. (Spells name)
4 No relation to the present quarterback. I just thought I'd
5 throw that in there.

6 (Laughter)

7 (Oath given)

8 CHAIRMAN GALASSIE: Staff report, please.

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

10 The applicant proposes to discontinue its
11 26-bed skilled nursing service at Freeport Memorial
12 Hospital in Freeport, Illinois. There is no cost to this
13 project. The anticipated project completion date is
14 November 30th, 2011. No public hearing was requested, and
15 no letters of support or opposition were received by the
16 State Board Staff.

17 Thank you, Mr. Chairman.

18 CHAIRMAN GALASSIE: Thank you.

19 Any comments for the Board?

20 MS. CUTLER: I do have ten additional letters
21 of support for the project. No other comments other than
22 that.

23 CHAIRMAN GALASSIE: Thank you very much.

24 And I will open this up to any questions, if

1 any, by the Board.

2 (Pause)

3 CHAIRMAN GALASSIE: Hearing none, I will
4 propose a motion to approve Project 11-064 for the
5 discontinuation of a 26-bed Long-Term Care category of
6 service, located in Freeport, Illinois.

7 MS. OLSON: So moved.

8 MR. BURDEN: Second.

9 CHAIRMAN GALASSIE: Moved and seconded. Roll
10 call, please.

11 MR. DART: Motion made by Ms. Olson, seconded
12 by Dr. Burden.

13 Dr. Burden?

14 MR. BURDEN: Yes.

15 MR. DART: Mr. Eaker?

16 MR. EAKER: Yes.

17 MR. DART: Justice Greiman?

18 MR. GREIMAN: Yes.

19 MR. DART: Mr. Hayes?

20 MR. HAYES: Yes.

21 MR. DART: Mr. Hilgenbrink?

22 MR. HILGENBRINK: Yes.

23 MR. DART: Ms. Olson?

24 MS. OLSON: Yes.

1 MR. DART: Mr. Sewell?

2 MR. SEWELL: Yes.

3 MR. DART: Chairman Galassie?

4 CHAIRMAN GALASSIE: Chairman votes yes.

5 MR. DART: Eight to zero.

6 CHAIRMAN GALASSIE: Motion passes. Thank
7 you. Have a good drive back to Freeport.

8 Item No. 11-062, Illinois Center for Foot and
9 Ankle Surgery. We have no public comment, so if the
10 gentleman would introduce himself, spell your name, and be
11 sworn in, please.

12 MR. ROGAL: Good afternoon. My name is Ira
13 Rogal from Shea, Paige and Rogal, consultant to the project
14 (spells name).

15 (Oath given)

16 CHAIRMAN GALASSIE: Thank you.

17 Staff report?

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

19 The applicant proposes to discontinue its
20 limited specialty ASTC in Oak Lawn, Illinois. There are no
21 costs to this project. The anticipated project completion
22 date is November 30th, 2011. No public hearing was
23 requested, and we did not receive any support or opposition
24 letters regarding this project.

1 Thank you, Mr. Chairman.

2 CHAIRMAN GALASSIE: Thank you.

3 Comments for the Board?

4 MR. ROGAL: Given the last two projects, I
5 will waive any comments.

6 CHAIRMAN GALASSIE: Thank you very much.

7 Are there any questions from the Board
8 regarding the discontinuation of this Surgical Treatment
9 Center in Oak Lawn, Illinois?

10 MR. BURDEN: Is John Grady a podiatrist, an
11 orthopedic surgeon, chiropractor?

12 MR. ROGAL: Podiatrist. It was a
13 single-specialty podiatric center.

14 MR. BURDEN: He left to go to other cities.
15 Wasn't Oak Lawn productive enough for him?

16 MR. ROGAL: Dr. Grady is still there. The
17 facility was for his practice, and two of the other doctors
18 who were in his practice found better cities, I think.

19 MR. BURDEN: And the doctor is retiring or--

20 MR. ROGAL: No, he's still there. The nature
21 of his practice has evolved over the years, and he finds --
22 he did do a substantial amount of surgery at the center in
23 earlier years, but he's not doing that anymore.

24 MR. BURDEN: But he's closing down his center?

1 MR. ROGAL: He's closing down the center.
2 There are also physician offices there, and will remain as
3 his primary physician office.

4 CHAIRMAN GALASSIE: Other questions from
5 Board members?

6 MR. CARVALHO: A quick one or two. So, the
7 facility will remain, the practice will remain, it just
8 won't be licensed as an ASTC?

9 MR. ROGAL: Yes.

10 MR. CARVALHO: Okay. So, everything else
11 stays the same. When did this become licensed as an ASTC?

12 MR. ROGAL: I believe 2003.

13 MR. CARVALHO: Okay. Thanks.

14 CHAIRMAN GALASSIE: Any other questions?

15 (Pause)

16 CHAIRMAN GALASSIE: Hearing none, I'll
17 entertain a motion to approve Project 11-062 for the
18 discontinuation of a limited specialty Ambulatory Surgical
19 Treatment Center, located in Oak Lawn, Illinois.

20 MR. HILGENBRINK: so moved.

21 MR. SEWELL: Seconded.

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

24 MR. DART: Motion made by Mr. Hilgenbrink,

1 seconded by Mr. Sewell.
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: Chairman votes yes.
18 MR. DART: eight in the affirmative.
19 CHAIRMAN GALASSIE: Motion passes.
20 Congratulations.
21 Let the record show that I'm sure that the
22 physicians moved to different communities, not better
23 communities.
24 (Laughter)

1 CHAIRMAN GALASSIE: Moving on to Item 11-055,
2 Transitional Care Center of Naperville. We do have one
3 public comment. If you would present yourself, introduce
4 yourself. No need to be sworn in, and you have a
5 two-minute limitation, if you can please adhere to that.
6 Thank you very much.

7 MS. SWITZER: Good afternoon. Thank you. My
8 name is Patricia Switzer, representing Lexington Healthcare
9 Network, in opposition to the proposed project.

10 This project is designed for the sole purpose
11 of capturing maximum reimbursement. The facility will not
12 admit Medicaid patients, as noted several times in the
13 application. The facility will not serve a younger
14 population. All of the applicant's projections and
15 business plan assumptions are based on residents aged 65
16 and older. The project does not propose different or
17 enhanced services. Again, the application itself notes
18 several existing facilities which provide the same level of
19 care and services. The application provides no
20 documentation of improved outcomes or level of quality.

21 What the application does say? Transitional
22 care center will have a competitive advantage, because the
23 high acuity focus does not require payors to subsidize
24 long-term patients in the facility who are reimbursed by

1 lesser payors.

2 While the proposed facility may be nicer, this
3 state will be achieved through restrictive financial
4 admission policies. The unfortunate result is a negative
5 impact on the provision of care to low-paying and no-pay
6 residents. It is no secret that nursing homes providing
7 the same services as the proposed project, but bearing
8 their fair share of the Medicaid caseload, need other payor
9 sources to subsidize that caseload, just as hospitals use
10 cardiac and orthopedic programs to subsidize emergency and
11 neonatal services.

12 MR. MORADO: Thirty seconds.

13 MS. SWITZER: If new facilities are permitted
14 to proliferate based solely on enhanced amenities and
15 better financial classification, existing nursing homes,
16 whose revenues have been siphoned away, will have no
17 resources to continue to care for all patients, regardless
18 of ability to pay.

19 Thank you for your attention to these
20 comments.

21 CHAIRMAN GALASSIE: Thank you. Have a good
22 day.

23 Representatives from Transitional Care Center
24 of Naperville, we would ask you to introduce yourselves,

1 spell your names for the Recorder, and be sworn in, please.

2 Welcome.

3 MR. CARVALHO: Mr. Chair, could you ask
4 Ms. Switzer to give us that in writing. I think I can use
5 that in the future.

6 CHAIRMAN GALASSIE: Ms. Switzer, if you'd
7 like to submit your comments in writing, Mr. Carvalho would
8 love to have it for future purposes.

9 MS. SWITZER: As long as the purposes are not
10 nefarious, I'd be happy to.

11 CHAIRMAN GALASSIE: I cannot testify to that.

12 (Laughter)

13 MR. CLOCH: Brian Cloch (spells name).

14 MR. SCHREIBER: Jason Schreiber (spells name).

15 MR. DIALS: Christopher Dials (spells name).

16 (Oath given)

17 CHAIRMAN GALASSIE: Good afternoon.

18 I'm going to ask for Staff report first.

19 Mr. Constantino, Staff report on this.

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

21 The applicants propose to establish 120-bed
22 skilled nursing care facility in approximately 72,000 gross
23 square feet of space. The total cost of the project is
24 approximately \$18.3 million. The project completion date

1 is February 28th, 2014. No public hearing was requested,
2 and no letters of support or opposition were received.

3 Thank you, Mr. Chairman.

4 CHAIRMAN GALASSIE: Thank you very much.
5 Mr. Cloch?

6 MR. CLOCH: Thank you. My name is Brian Cloch
7 I'm the CEO of Transitional Care Management. I'd like to
8 thank the Staff for preparing such a thorough report.
9 Thank you also to the Board for being here today and
10 lending your expertise to discover the merits of this
11 project. I'd like to thank you in advance for considering
12 this project, due to consideration by -- we recognize
13 up-front this is much like our transitional care modernized
14 project the Board approved back in June. It is a square
15 peg in a round hole scenario. It needs to be understood
16 not only on the standard merits, but also on special merits
17 this type of innovation brings to the system.

18 As you may recall from the last time we met,
19 I've worked in senior housing for the last thirty years,
20 have owned and operated managed care, sub-acute,
21 rehabilitation, skilled nursing facilities, assisted living
22 and independent-living senior housing. As you know,
23 building purposeful-built transitional care has been a
24 dream of mine since my father-in-law rehabbed in a well-run

1 nursing home following hip replacement surgery in 2008. He
2 had the finest of facilities and services, medical care,
3 yet begged me, "Get me out of here." It was the best of
4 the best, and he hated it. I knew there had to be a better
5 way.

6 Transitional care is a successful model of
7 care that is happening across the country that addresses
8 the long-standing, untapped need to reform short-term
9 rehabilitation care. Like the introduction of assisted
10 living 20 years ago and the introduction of supported
11 living 10 years ago, stand-alone transitional care is the
12 next natural evolution for our industry. So, let me tell
13 you a little bit more about the Naperville Transitional
14 Care project.

15 Transitional Care Center of Naperville is not
16 another traditional nursing home. Our goal is not to build
17 another nursing home; rather, our objective is to reinvent
18 the post-acute experience. As we proposed in CON for
19 Arlington Heights, which the Board granted, we intend to
20 create a new post-acute delivery model. I'm sure that
21 either you or a friend or relative has needed this level of
22 care at some point. In fact, the entire Board of Trustees
23 at Arlington Heights, where we received preliminary zoning
24 approval just last week, had a story to tell about the

1 displeasure they had with the current system. We all know
2 that the current options for many of us are simply not
3 optimal.

4 The Naperville Recovery Center will help
5 bridge the distance between illness and recovery by
6 providing a healthy balance of the finest in facilities,
7 treatment protocols and highly-skilled care, along with the
8 comfort and convenience of a non-institutional setting. We
9 will offer primarily private rooms with private baths and
10 optional patios, home-like furnishings, comfortable
11 accommodations for guests, restaurant-style dining options,
12 conveniences to minimize disruption and offer privacy,
13 signature spotlight amenities, a dedicated focus on
14 post-hospital care rehabilitation as opposed to a primarily
15 long-term focus.

16 Transitional care of Naperville will address
17 the specific and under served need and offers a welcome,
18 innovative alternative, while helping control costs and
19 minimize the higher cost alternative care settings when
20 they're not medically necessary.

21 There are several reasons why this project
22 should be approved. First, let's talk about need. As the
23 report states, there's a current 164 bed need, and a 636
24 bed projected need by 2015, as defined by the State of

1 Illinois in their inventory update in the service area.
2 The need has been clearly defined and documented.
3 Furthermore, the majority of facilities within a reasonable
4 drive time pose very high occupancies, considering we are
5 reporting on licensed beds versus operating beds. Some of
6 the traditional nursing homes in the area fall below the
7 target occupancy, as reflected, of licensed beds. It's
8 important to ask why. First of all, many of these licensed
9 beds are not because they are not in service. The State's
10 occupancy calculations are based on licensed beds, not
11 actual operating beds. Many of these licensed beds have
12 been taken out of service because consumers, like I and
13 you, do not want dual or triple occupancy. They cannot be
14 occupied if they don't exist. In reality, when using
15 operating or functional beds as the matrix, many of these
16 facilities are fully or near fully occupied.

17 Of note is the fact that often times
18 unoccupied beds are located in continuing care retirement
19 communities that do not accept admissions from the general
20 market, or facilities that chose not to accept Medicaid.
21 Reported utilization is on all skilled beds, including
22 long-term and short-term. Our experience is that within
23 this mix, short-term utilization is typically higher than
24 long-term. Often communities with low occupancy also have

1 low quality ratings, and cause and effect relationship
2 could be implied.

3 No other -- no area provider listed in the
4 report, zero percent, offer stand-alone, purpose-built,
5 specialized, short-term care. Actually, there are no
6 duplication of services. No one is offering short-term
7 care in this innovative manner. Rather, these existing
8 traditional nursing homes provide an institutional model of
9 custodial care for geriatric residents that is supplemented
10 with a small rehabilitation unit, designed to capture
11 Medicare reimbursement when their internal residents return
12 from the hospital. The existing inventory is probably a
13 combination of old and neglected buildings, semi-private,
14 with dual occupancy rooms, shared bathrooms, showers down
15 the hall, a small therapy room with outdated equipment.

16 While other fine medical facilities in the
17 area have been upgraded, post-acute care in the area by
18 comparison and in general is antiquated. The hospital does
19 not -- itself does not offer these services. No
20 duplication there. In fact, Pam Davis, president and CEO
21 of Edward hospital, wrote, "We anticipate that Transitional
22 Care of Naperville will become a crucial destination of
23 Edward Hospital. We look forward to the increased access
24 to high quality, post-acute care that will be provided as a

1 result of the proposed project."

2 The only local alternative to traditional,
3 primarily custodial care, environment is home care. I can
4 promise you that in many cases, home care solution is not
5 always the best option.

6 The overwhelming majority of these nursing
7 homes primarily care for an older population.
8 Transitional Care of Naperville will appeal to a broader
9 range of patients who are being discharged sicker and
10 quicker from the hospital. There is no duplication of
11 services. Transitional Care of Naperville will reach
12 people with needs that are not currently being met by the
13 existing nursing homes. People like, Dave Zinn, 49, who
14 recently underwent cervical spine surgery and wrote a
15 support letter for Transitional Care, because he found that
16 as a divorced, single father, the only option of care
17 coming out of the hospital was a nursing hospital that
18 served an elderly population. People like -- hundreds of
19 people who provided support letters for our concept do not
20 want to share a room or walk down the hall to use a
21 bathroom. People like other area healthcare professionals,
22 doctors, nurses and therapists, hospital CEO's and
23 insurance providers who wrote in support of our project,
24 they know there ought to be a better way.

1 When all of this is taken into consideration,
2 it is clear that Transitional Care Naperville is targeting
3 an under served market. As such, existing facilities do
4 not meet the needs of this market.

5 Finally, and most importantly in my opinion,
6 let's talk about quality. A vote for Transitional Care is
7 a vote for quality. Transitional Care's specialty focus
8 will enhance outcomes in patient experiences. Transitional
9 Care nurse-to-resident ratios are much higher than a
10 typical nursing home. Transitional Care will coordinate
11 with area physicians and hospitals to offer critical
12 pathways that address high rehabilitation and complex care
13 needs.

14 And, lastly, multiple studies show that the
15 healing design like that which Transitional Care proposes
16 can improve a patient's outlook on care, increase patient's
17 satisfaction, and ultimately help support a client's
18 journey toward recovery. In summary, healthcare reform
19 will change our norm. Short length of stays and increase
20 in outpatient procedures will continue to result in
21 discharging people sicker and quicker, thereby driving an
22 increased need for high quality, short-term, high acuity,
23 post-acute care. There is a stated and documented
24 published need for 636 beds, come 2015, in the planning

1 area that Transitional Care Naperville will only begin to
2 address. Furthermore, there is a desire on both part of
3 the consumers and healthcare community to bring a new
4 choice to the marketplace. This is not really a
5 conversation about duplication or maldistribution. It is
6 truly a conversation about status quo and innovation. In a
7 time when money is scarce costs are soaring and our nation
8 is aging, we need to explore cost-effective,
9 customer-centered, innovative alternatives to healthcare's
10 current status quo. Transitional Care of Naperville offers
11 choice and offers quality and offers cost savings.

12 Transitional Care is the model of the future.
13 Hospitals know it, doctors know it, insurers know it and
14 patients want it. Please vote in favor of bringing
15 innovation to Naperville. Thank you.

16 CHAIRMAN GALASSIE: Thank you. I will open
17 this up to questions from Board members.

18 MS. OLSON: I have a question, or I'd like you
19 to respond, because I believe we were accused in the public
20 comment of skimming the cream of the geriatric long-term
21 patient. You know I love your model. I told you that
22 before. Are you going to assure me that that's not what
23 you're doing here?

24 MR. CLOCH: Absolutely sure. We have budgeted

1 to take Medicaid right now, so I don't know where that
2 information came from. That's number one.

3 Number two is we're working very closely with
4 the Department, HFS, the Medicaid agency in the state, to
5 develop specific reimbursement tied to this population, and
6 the reason for that specifically is because, when we talk
7 about cost savings, that's coming directly out of acute
8 care. So, acute care rates -- I was in a meeting
9 yesterday, and a hospital CEO said the average acute-care
10 rate was 2,500. Now, that was the market he was in, but,
11 no, we're looking at our rates being around five or \$600 a
12 day. So, when you compare it to an acute care rate, it's
13 significantly below that.

14 What we're looking to do is to be able to get
15 patients out of the hospital sicker and quicker, to a model
16 that comes in. When you look at facilities that do the
17 cross-subsidization that was referred to by the public
18 speaker before me, the reality of that cross-subsidization
19 means that even in facilities I operate today, where we
20 have this mix population, we're using the Medicare to
21 subsidize the Medicaid, which means it has a direct
22 negative effect on staffing. So, it doesn't give us the
23 ability to take a sicker or quicker patient, because our
24 staffing ratios are maybe 1 to 15, 1 to 20, wherein what

1 we're building, we're proposing a staff ratio of 1 to 8 or
2 1 to 10. So, by having that extra resource, we're able to
3 let that translate into higher staffing ratios, so it
4 enables us to take those patients out of the hospital
5 faster.

6 MS. OLSON: And just to follow up, two things.
7 What would you predict your average length of stay would
8 be? I think you said on the other it was like 56 days or
9 something like that?

10 MR. CLOCH: You know, we have information --
11 we have some experience, because we operate facilities
12 currently that have some sections of this in our buildings,
13 and depending on the diagnosis, we're seeing, for rehab,
14 orthopedic patients, 14 to 17 days. I think COPD, CHF
15 patients might be a little bit longer.

16 MS. OLSON: But you're talking days, you're
17 not talking years?

18 MR. CLOCH: No. Years are what's happening in
19 assisted living. The whole paradigm has shifted. It's not
20 custodial. We anticipate less than 30-day length of stay.

21 CHAIRMAN GALASSIE: Other questions by Board
22 members?

23 Mr. Carvalho and then Dr. Burden.

24 MR. CARVALHO: I apologize, Mr. Cloch. You

1 talk faster than I listen.

2 MR. CLOCH: I've been accused of that before.

3 Sorry.

4 MR. CARVALHO: What amount of Medicaid do you
5 anticipate?

6 MR. CLOCH: We have in our budget 18 percent.

7 MR. CARVALHO: And then the balance is
8 Medicare or private insurance?

9 MR. CLOCH: Commercial insurance, Medicare, a
10 variety of whoever pays for that short-term stay.

11 MR. CARVALHO: Because one of the -- just to
12 nip that one off then, you note that -- in the analysis, in
13 fact, Michael said in the State Agency Report, one of the
14 ways to deal with, the two ways we look at need -- because,
15 as you know, it's not just bed need, it's also the
16 occupancy of other homes. It's a combined -- sometimes
17 people focus on whichever one is okay for their analysis.
18 But it's both. So, you do address both, the fact that
19 there is -- if there's bed need and if there's occupancy
20 rates, then you address the occupancy rates based on the
21 quality and other issues. But one of the things in there
22 where one can overcome a deficiency is pointing out
23 restrictive admission policies in other homes. So, I just
24 didn't want to make sure that you weren't going to become

1 the home with the restrictive admission policy that the
2 other future applicants will point to and say, "That's why
3 they over came need." So, you are not going to have a
4 restrictive admission policy, you're going to have a full
5 range of payors?

6 MR. CLOCH: I'll answer that with a specific
7 answer, and that is that we are committing this building to
8 a short-term stay population. So, if we have any
9 restrictive admission policy, it would be to somebody who
10 is using us as how we are designed and built as a
11 transitional facility. If somebody has the intention of
12 coming to our building and living the rest of their lives
13 in our building, they wouldn't be welcome, no matter what
14 payor status they have.

15 MR. CARVALHO: In addition, as opposed to the
16 other answer is you would reflect the payor mix of your
17 referring institutions. If Naperville doesn't have a high
18 Medicaid population, they can't be referring you a high
19 Medicaid population.

20 MR. CLOCH: Correct.

21 CHAIRMAN GALASSIE: Dr. Burden?

22 MR. BURDEN: I have two questions. You
23 referenced Pam Davis, who is well-known to us older members
24 here, having been in front of us. I don't see anything

1 written from her regarding what you quoted her as saying.
2 They're going to be responsible for referring 400 patients
3 to you? Is that your opinion of what she said, or has
4 there been something written in her -- by her to us or to
5 you stating that?

6 MR. CLOCH: I don't have the support letter in
7 front of me.

8 MR. BURDEN: You got one from her at some
9 point?

10 MR. CLOCH: Yes. It should be in the package.

11 MR. BURDEN: I don't -- it's not in the -- at
12 any rate, that's one question I had. The other is I think
13 the State Agency must be confused on page 9, because how
14 are you doing in Arlington Heights?

15 MR. CLOCH: We just got approved on June 28th.
16 We just got the zoning last Monday night, so we haven't
17 even started construction.

18 MR. BURDEN: Is HUD money involved in this
19 one? Since you're financing 95 percent of this purchase,
20 that's pretty good going.

21 MR. SCHREIBER: We do have a support letter
22 from CWCapital, and they're to provide the HUD financing
23 for Arlington Heights as well as for this project. HUD is
24 going to finance over 500 nursing homes this year, so it's

1 a very, very robust program. They're actually adding staff
2 to process their applications. So, we feel like that's a
3 very, very viable alternative for us on the debt side.

4 MR. BURDEN: I guess so. I think there are a
5 lot of builders out there wonder how it is you got that
6 kind of dough and you're only putting down five percent and
7 ready to go.

8 MR. SCHREIBER: That may be a typo. It's an
9 85 percent of cost program.

10 MR. BURDEN: Still good.

11 MR. SCHREIBER: Which is extraordinarily good.

12 CHAIRMAN GALASSIE: Other questions by Board
13 members?

14 MR. SEWELL: Is it correct -- I guess I'm
15 asking the staff this. Is it correct that the occupancy
16 rates that are referred to in the State Agency Report are
17 based on licensed beds?

18 MR. CONSTANTINO: Yes, sir.

19 MR. SEWELL: As opposed to beds in service.

20 MR. CONSTANTINO: Yes, sir.

21 MR. SEWELL: Then what would a home have to do
22 to put beds in service that they previously did not have in
23 service? Would they have to come to us for that?

24 MR. CONSTANTINO: No, sir.

1 MR. SEWELL: They could just do it?

2 MR. CONSTANTINO: Yes, sir.

3 MR. SEWELL: Then I would turn to you. I
4 guess you're saying that these percentages are off because
5 the actual beds that are in service are lower, there are
6 fewer beds in service?

7 MR. CLOCH: As an example, a facility we
8 manage right now was licensed -- Evergreen.

9 MR. SCHREIBER: Yeah, Evergreen was licensed
10 for 232 beds, and we view the practical capacity as about
11 175.

12 MR. CLOCH: So, when you look at the
13 occupancy, it's around 54 percent, and we don't
14 anticipate --

15 MR. SEWELL: But they could put those beds in
16 service.

17 MR. SCHREIBER: They functionally would have
18 the right to do that, but looking at the most -- the 6
19 closest competitors constructed in 1970, 1964, 1979, they
20 have an average age of over 30 years, and so those were
21 configured to have 3 and 4 people to a room. So, while
22 they functionally could do that, from a consumer
23 perspective, who are they really going to get to move in as
24 that third or fourth person in a room?

1 MR. SEWELL: And in the financial thing, could
2 you address this non-compliance with the projected cushion
3 ratio.

4 MR. SCHREIBER: Sure. I mean, in part the
5 cushion ratio basically is a measure of cash liquidity
6 versus ongoing expenses, and so, given the fact that we're
7 basically starting this project day one with zero cash
8 flow, essentially dollars will flow out before they start
9 to flow in, and so, over time that cushion ratio will build
10 up. But I think because of the start-up nature of this and
11 sort of the cycle that it takes to lease up -- I think we
12 projected twelve months to stabilization -- we have
13 allocated capital to cover that over time. But when you do
14 a cushion ratio calculation, it doesn't look good for the
15 first couple of years, and then it begins to improve. I
16 believe we're compliant by -- I think that test is measured
17 in year three. By year four or five, we're compliant with
18 that.

19 MR. SEWELL: So, you think you'll be there by
20 2016 or something.

21 MR. SCHREIBER: Yes.

22 MR. SEWELL: Your estimate is that you will
23 not by 2015, because that's post-construction.

24 MR. SCHREIBER: Right, post-construction, post

1 lease-up. It's really just a timing consideration, given
2 the fact that we're starting day one with zero revenue and
3 largely a full complement of expenses, because we'll be
4 fully staffed before we take that first resident. So, we
5 basically start from behind, work our way to zero and then
6 start growing positively over time.

7 MR. DIALS: If I could go back to the question
8 from Dr. Burden, the letters from Pam Davis are on pages
9 111 and 112 of the application.

10 MR. BURDEN: Thank you.

11 CHAIRMAN GALASSIE: Any other questions by
12 Board members?

13 MR. CARVALHO: Mr. Chair.

14 Richard, right after that seminar on end-stage
15 renal dialysis, we probably want to schedule the one on the
16 issue that you were following up on, because this is a
17 constant conundrum. It's not just long-term care. It's
18 hospitals, too. Everybody has got licensed beds that are
19 fully used, where applicants come in who are new, they ask
20 you to look at the vacancy and occupancy rates with that in
21 mind, and for the applicants who are coming in on existing
22 projects, they tell you that we can't de-license those beds
23 because our lenders will get mad at us. So as long as I've
24 been here there is this issue of what do you do about the

1 fact that we've got more beds licensed than are being
2 staffed and are being used, and some of them, it's just a
3 matter of staffing is down, and some of it's a matter that
4 nobody is ever going to put four people in that room or the
5 space has been cannibalized. If you go to UIC Hospital,
6 the number of licensed beds there, if you walk through, are
7 not the number of beds that they were --

8 CHAIRMAN GALASSIE: Another discussion for a
9 retreat.

10 MR. CARVALHO: Yes.

11 CHAIRMAN GALASSIE: Thank you. Any other
12 questions by Board members.

13 Hearing none, do I have a motion to approve
14 Project 11-055, the establishment of 120-bed, skilled care
15 facility in Naperville, Illinois?

16 MR. HILGENBRINK: So moved.

17 MS. OLSON: Second.

18 CHAIRMAN GALASSIE: Moved and seconded. Roll
19 call, please?

20

21 MR. DART: Motion made by Mr. Hilgenbrink,
22 seconded by Ms. Olson.

23 Dr. Burden?

24 MR. BURDEN: Yes.

1 MR. DART: Mr. Eaker?

2 MR. EAKER: I'm going to preface my vote by
3 saying that what you're proposing to do continues to siphon
4 off the life blood of the long-term care industry, in my
5 estimation. All long-term care facilities depend pretty
6 much on the short-term, high reimbursement rate patient to
7 help float their facility, so to speak. I think that your
8 projects and those similar will continue to bring down the
9 industry. I vote no.

10 MR. DART: Justice Greiman?

11 MR. GREIMAN: Aye.

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: No.

20 MR. DART: Chairman Galassie?

21 CHAIRMAN GALASSIE: Yes.

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

24 CHAIRMAN GALASSIE: Motion passes.

1 Congratulations. Good luck on your second facility.

2 Moving forward to Item 11-065, Manor Court of
3 Princeton. We have no public comment requested, to our
4 knowledge. If so, you should advise now.

5 Hearing none, applicants, please come up,
6 introduce yourselves, spell your names, be sworn in. Thank
7 you very much.

8 MR. KNIERY: Thank you, Mr. Chairman. My name
9 is John Kniery (spells name), and with me today is Mr. Ron
10 Wilson (spells name).

11 (Oath given)

12 CHAIRMAN GALASSIE: Thank you. Staff report,
13 Michael?

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

15 The applicants are proposing to convert the
16 remaining 22 shelter-care beds to skilled care and
17 construct a single-story addition containing 27 skilled
18 care beds, for a total of 49 long-term care beds. This
19 modernization will result in a total of 125 long-term care
20 beds at this facility. The total cost of the project is
21 approximately \$3 million. The project completion date is
22 August 31st, 2012.

23 Thank you, Mr. Chairman.

24 CHAIRMAN GALASSIE: Thank you. Comments for

1 the Board?

2 MR. KNIERY: I only have one. The only
3 negative issue is the timing of the project. We have put,
4 as Mike just said, the closing date or completion date of
5 August of next year, and due to the lateness of this year,
6 we really need until March of 2013, considering we probably
7 won't get in the ground until March of next year.

8 CHAIRMAN GALASSIE: So you're asking for an
9 extension from August 12th to March 13th?

10 MR. KNIERY: Right.

11 CHAIRMAN GALASSIE: So that's a change of
12 completion date?

13 MR. KNIERY: Correct.

14 CHAIRMAN GALASSIE: All right. The Board can
15 consider that and approve it or not approve it. Any other
16 comments for the Board?

17 MR. KNIERY: None. I would open it up for
18 questions.

19 CHAIRMAN GALASSIE: Hearing none, thank you.
20 Questions from the Board?

21 (Pause)

22 CHAIRMAN GALASSIE: Hearing none, I am going
23 to propose a motion to approve Project 11-065 for the
24 modernization of 125-bed skilled care facility in

1 Princeton, Illinois, with a completion date extended from
2 August of '12 to March of 2013.

3 MR. SEWELL: So moved.

4 MR. BURDEN: Second.

5 CHAIRMAN GALASSIE: Moved and seconded.

6 MR. DART: Motion made by Mr. Sewell, seconded
7 by Dr. Burden.

8 Dr. Burden?

9 MR. BURDEN: Yes.

10 MR. DART: Mr. Eaker?

11 MR. EAKER: Yes.

12 MR. DART: Justice Greiman?

13 MR. GREIMAN: Yes.

14 MR. DART: Mr. Hayes?

15 MR. HAYES: Yes.

16 MR. DART: Mr. Hilgenbrink?

17 (No response)

18 MR. DART: Ms. Olson?

19 MS. OLSON: Yes.

20 MR. DART: Mr. Sewell?

21 MR. SEWELL: Yes.

22 MR. DART: Chairman Galassie?

23 CHAIRMAN GALASSIE: Chair votes yes.

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

1 CHAIRMAN GALASSIE: Motion passes.
2 Congratulations. And the record should note March 31st of
3 2013. Member Hilgenbrink, while present, was not present
4 for the vote, if that makes any sense.

5 Moving on to number -- Item 11-004, Crest Hill
6 Dialysis. We do have five public comment requests. We
7 would ask those individuals that are planning to give
8 public comment to come up and introduce yourself. You do
9 not have to be sworn in. We do ask that you try to stay
10 closely to our two-minute time schedule. We will try to be
11 respectful, though you are our last item on our application
12 agenda today.

13 MR. CHAWLA: My name is Dr. Bhuvan Chawla, MD,
14 I am the senior-most nephrologist in Joliet. I would like
15 to thank the Board for issuing an Intent to Deny this
16 project last time. This was -- I would urge --

17 CHAIRMAN GALASSIE: I'm sorry to interrupt,
18 Doctor. You've giving public comment?

19 MR. CHAWLA: Yes.

20 CHAIRMAN GALASSIE: Okay. Opposition. Thank
21 you very much.

22 MR. CHAWLA: Yes. I would like to urge the
23 Board to uphold the negative vote. I limited to the
24 two-minute rule and not allowed to provide any additional

1 testimony, per the rules. I would like to make the Board
2 aware that the inventory of stations is now up to 72. This
3 project was rejected at 55-station oversupply. I think
4 that the applicant is incorrect in asking the Board to
5 ignore stations in the pipeline. Right now there are 38
6 stations that are being approved and under development.

7 I would also like to make the Board aware that
8 the incidents of end-stage renal disease from Crest Hill,
9 when you calculate the small population of Crest Hill,
10 equates to 89 patients per year, and it's hard to justify
11 \$2 million project for that volume.

12 The application makes mention of the issue of
13 competition. DaVita claims it will bring competition to
14 the market. It omits to tell the Board that it is in the
15 process of buying out the Silver Cross Hospital dialysis
16 program, which was announced by the CEO of Silver Cross
17 nine days before the additional information was submitted.

18 The application has added some letters from
19 elected officials. I did meet with both of them. They
20 acknowledged that they did not understand the CON process
21 and appreciated my making them aware of the absence of
22 need. Letters from certain patients were included. The
23 average distance of those patients from Sun Health's
24 facility was 4.26 miles. I don't think that justifies the

1 need.

2 Once again, I would ask the Board to vote no.
3 Five members voted against this project last time, three
4 voted for. I would ask for unanimous rejection of this
5 project. Thank you.

6 CHAIRMAN GALASSIE: Thank you, Doctor.

7 I believe we have four more individuals for
8 public comment in support of the project. Good afternoon.
9 welcome. Just introduce yourself.

10 MS. LOFRANO: My name is Ms. Lofrano (spells
11 name), and I'm here today to testify in support of the
12 proposal to establish a dialysis facility in Crest Hill.

13 Thanks to the efforts of the nephrology --
14 Northeast Nephrology Group, my husband became healthy
15 enough to obtain a kidney transplant, because they kept him
16 alive for three and a half years before he got one from our
17 daughter. He was a patient at Northwestern, and I wouldn't
18 have -- we wouldn't have come back to this group if we
19 didn't think they were the very best in the area. Patients
20 and their families face many challenges when one of their
21 loved ones has end-stage renal, and one of the most
22 significant difficulties is the time commitments with
23 dialysis. You have to find transportation for them
24 sometimes. They want to keep their own lives as normal as

1 possible, and it's very difficult if you have to drive far.
2 We actually moved so that we could be closer to a dialysis
3 facility and closer to the doctors.

4 This particular group is -- I can't say enough
5 about how conscientious and caring they were, and, in my
6 mind, they saved his life numerous times, more times than I
7 care to remember. The burden of transportation exacerbates
8 an extremely stressful time for both the families and the
9 patient, and so, to have to drive any longer distance than,
10 say, a half mile is really a difficult thing, because
11 oftentimes they have other health issues, and I know there
12 were times my husband didn't make it home the way he should
13 have or I found him passed out in the driveway.

14 MR. MORADO: Thirty seconds please.

15 MS. LOFRANO: At any rate, the proposed
16 dialysis, I know, will improve access and reasonable
17 transportation times. The Northeast Nephrology Group I
18 cannot say enough about. I love them all dearly. Thank
19 you for your time, and I hope you'll approve this proposal.
20 I know that the patients in the Crest Hill and Joliet area
21 will absolutely benefit from the care from the doctors and
22 this facility. Thank you.

23 CHAIRMAN GALASSIE: Thank you very much.

24 Appreciate it.

1 Good afternoon. If you could introduce
2 yourself and spell your name.

3 MS. MULDEY: My name is Ann Muldey (spells
4 name). I'm here to testify in support of this dialysis
5 facility in Crest Hill. My husband just started on
6 dialysis, and it has become a burden from traveling time to
7 getting up early to get him there on time. We too face the
8 time that he's in dialysis, sometimes three to five hours
9 and three times in a week or three days a week. It is a
10 burden to me, because I either have to go and take him,
11 because my doctor suggests I take him there and bring him
12 back home, because he's not used to this treatment. But he
13 is doing better. He loves the doctors, and this facility
14 is really helping him a lot. It's just that we, like I
15 say, are new to all of this, and yet it's already starting
16 to take a toll on us with travel time. And with the
17 facility being in Crest Hill, it will provide easier access
18 for us and the surrounding community. I know several
19 people in our area that go to the same facility that we do
20 now, and they would love to have one in Crest Hill, closer
21 to home, as we say.

22 MR. MORADO: Thirty seconds, please.

23 MS. MULDY: I'm confident that the
24 collaboration between DaVita and Northeast Neuropathy (sic)

1 consultants will be good for the patients and I -- please,
2 I wish you would approve this establishment, Crest Hill
3 Dialysis. Thank you.

4 CHAIRMAN GALASSIE: Thanks.

5 Good afternoon.

6 MS. RIVERA: Good afternoon. My name is
7 Beverly Rivera (spells name), and I'm testifying today in
8 support of the proposal to establish a dialysis facility in
9 Crest Hill. I would like to thank the Board for this
10 opportunity to express my support.

11 My husband is on dialysis but could not be
12 here today, because he currently in treatment. My husband
13 is 80 years old, in a wheelchair, and has been on dialysis
14 for one and a half years. My husband spends approximately
15 three to five hours in treatment, three days a week. Since
16 he is in a wheelchair, I drive him each time he has
17 treatment. I can't wait three to five hours for him at the
18 facility, so I need to drive to and from dialysis, taking
19 my husband to treatment and home after treatment. It often
20 takes us 35 minutes each way. This amounts to almost two
21 and a half hours, three days a week, for me to take him to
22 treatment, which is a significant time commitment. Any
23 time I could save would be very valuable to me.

24 The new facility would only take us 15

1 minutes, which will save me nearly an hour and a half each
2 day. Over a single week, that means I could save almost
3 five hours. It will also allow us to sleep in, which would
4 be very beneficial to my husband, as he needs his rest.
5 This facility will understandably make things easier for us
6 and surely many others in the community, as demonstrated by
7 other people speaking here today. The proposed dialysis
8 facility will improve access and provide reasonable
9 transportation times. This new facility will also surely
10 deliver the quality of care my husband deserves.

11 We think very highly of the doctors, and
12 believe a DaVita facility will be good for the community
13 and ourselves. Please approve the establishment of Crest
14 Hill Dialysis. Thank you.

15 CHAIRMAN GALASSIE: Thank you.

16 MR. GENE BANDOSZ: Good afternoon. My name is
17 Gene Bandosz (spells name). I am here with my Uncle Daniel
18 to my right. I would like to testify on behalf of my uncle
19 in support of DaVita's proposal to establish a new dialysis
20 facility in Crest Hill that is really needed. My uncle is
21 84 years old, and has been on dialysis for nearly a year.
22 He just kind of started this in March. He currently
23 receives his dialysis treatments at the Silver Cross Renal
24 West. The time he has to go is from three to six o'clock

1 in the afternoon, because that it is that well booked. It
2 is the last shift of the day, and sometimes he don't get
3 out of there until 6:30, 7 o'clock at night.

4 And Danny has lived in Crest Hill all his
5 life, for 57 years, and I just picked him up to bring him
6 here. We see how much closer it is to him. Once again,
7 Danny does drive to dialysis. He is 84 years old. He does
8 drive himself, but he doesn't get a ride -- his wife
9 doesn't have a license, so he has to come back and forth on
10 his own, and which I did say he only lives three miles from
11 the facility. So, we really would like to have your
12 support for this dialysis center, and here's living proof
13 of the guy that goes three days a week.

14 MR. DANIEL BANDOSZ: Yeah. Daniel Bandosz.
15 It takes me about half hour to go get my dialysis, and if I
16 could get in to Crest Hill, it would only take me three
17 minutes, and that's why I was trying -- you know, glad that
18 Crest Hill -- if we get it, I'll be glad. I ain't too good
19 at this.

20 CHAIRMAN GALASSIE: You're doing a great job.

21 MR. DANIEL BANDOSZ: But like I say, it's so
22 much closer. You don't have to worry about traffic or
23 negotiating in the winter time. I'm there in three
24 minutes, and I don't got no traffic to go through or

1 nothing, and it's real simple. So, I would really be glad
2 if they got it.

3 CHAIRMAN GALASSIE: Thank you, Mr. Bandosz.

4 MR. DANIEL BANDOSZ: That's about all I could
5 say.

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

8 MR. DANIEL BANDOSZ: Yeah, okay.

9 CHAIRMAN GALASSIE: I believe that closes
10 public comment. Thank you, and good luck to all of you.

11 And I would now ask for the representatives
12 from Crest Hill Dialysis to come to the table and introduce
13 yourselves, spell your names for our Recorder, and then
14 we'll swear you all in.

15 MS. DAVIS: Good afternoon. My name is Penny
16 Davis. I'm the Divisional Vice-President for DaVita in
17 Chicago. With me is Matthew Forsythe, who is our Regional
18 Director of Operations, and our counsel, Kara Friedman and
19 Anne Cooper from Polsinelli Shughart.

20 (Oath given)

21 CHAIRMAN GALASSIE: Thank you very much.

22 Staff report, please.

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

24 Before I get started on the Staff report, I'd like to make

1 a comment about the dialysis information. DaVita was also
2 asked to supply that information, and they are refusing to
3 provide the net revenue information for the same reason,
4 that it's confidential. I would like to make sure that
5 they provide us with the information that Fresenius was
6 asked to provide earlier this morning.

7 CHAIRMAN GALASSIE: Well, considering the
8 time of the day, with all due respect, can I just skip to
9 the finish? I'd rather not have another thirty-minute
10 discussion about why public information shouldn't be
11 submitted to a public body, because I personally am still
12 disappointed that that occurred. Perhaps a
13 miscommunication, and I'll chuck it off to that. But I
14 certainly think that after sitting here today, you have a
15 sense of what this Board is trying to get access to. We
16 would ask you to submit that information and to do so to
17 Mr. Constantino in a timely way. Timely to me means within
18 the next month.

19 MS. FRIEDMAN: If I may, if I'm understanding
20 what's being asked to be provided is Medicare cost reports
21 for each facility?

22 CHAIRMAN GALASSIE: We would accept the
23 Medicare cost report, which includes all revenues. We'll
24 accept that.

1 MS. FRIEDMAN: I understand that that is public
2 record. That is the first time that that request was made,
3 right now, and we are willing to provide you the Medicare
4 cost report.

5 MR. CONSTANTINO: No, you said that net
6 revenue was confidential, Kara.

7 MS. FRIEDMAN: Well, I'm not sure that the net
8 revenue by facility is on the Medicare cost report. I did
9 not want to jump up during the previous discussion.
10 Fresenius is providing that Medicare cost report.

11 CHAIRMAN GALASSIE: Let's not repeat what we
12 went through this morning. We'll take the Medicare cost
13 report and we'll review it, and I will I promise you if
14 it's not in the detail we are hoping to get, we will be
15 advising all of you again, and I trust we will all get to
16 the same place voluntarily. Thank you.

17 We've been sworn in. We have Staff report.
18 Comments for the Board?

19 MS. DAVIS: Okay. Thank you. At the July
20 Board meeting, we received several votes to approve this
21 proposal. We appreciate your thoughtfulness about this
22 project and know it's been a long couple days, so I'll try
23 to be very, very brief.

24 CHAIRMAN GALASSIE: That's quite all right.

1 MS. DAVIS: We've been working on this project
2 for nearly two years, and I appreciate the attention at
3 this late hour so I can highlight some of the merits of
4 this proposal.

5 First, I want to talk about DaVita's
6 commitment to patient quality, choice and access, as
7 provided in the supplemental information that we provided
8 to the Board. But some specific things I want to mention,
9 because you talk about charity, you talk about community.
10 We have raised in the last couple of years over \$3.4
11 million for the Kidney Trust, and what that does, that's
12 through our Tour DaVita Bike Ride and Kidney Awareness
13 Walks and Runs. That has provided 15,000 chronic kidney
14 disease screenings and over 1,200 grants to patients to
15 help pay for their needs around their dialysis. We have
16 local community service projects, over 128 of them provided
17 in the country. Locally, we just rehabilitated a park,
18 Washington Park, on Chicago's south side. Our teammates,
19 our employees, spent an entire Saturday of their own time
20 to do that. We have \$1.5 million in charitable work, and
21 are committed to education and training for its
22 populations. We hire locally, and then we provide all of
23 our employees with scholarships to go on, if they're a
24 patient care tech, to become a nurse, to become an

1 administrator. We have one of the most advanced programs.
2 I've seen lots of folks that we have hired move from being
3 a receptionist to being a nurse in a facility and even a
4 facility administrator right here in the Chicago market.
5 Our Bridge of Life program is international. We provide
6 programs in the Philippines, Cameroon, Guatemala, and other
7 places. Our Village Health Program, over 5,400 patients
8 have benefited from CKD or chronic kidney disease and
9 end-stage renal disease assistance. 20 percent lower
10 mortality in this group of patients. 94 percent of those
11 patients got flu vaccines. 25 percent had better
12 medication adherence and 8 to 16 percent fewer
13 hospitalizations.

14 We're very proud of the fact that we lead the
15 industry in clinical outcomes and are among the best in
16 virtually ever category. The resulting decrease in
17 mortality rates, hospitalization and infections has reduced
18 taxpayer costs by approximately \$509 million, as 89 percent
19 of our dialysis patients are served through Medicare or
20 other government programs.

21 While there's a technical excess of stations
22 in the four-county planning area, the computation does not
23 reflect the access issues that the chronically-ill patient
24 faces, as you heard earlier. Need data almost never tells

1 the whole story. That's precisely why this Board exists.
2 It can examine and weigh the facts that are difficult to
3 capture in raw data. In this instance, recognize that the
4 dispersion of the residents of the planning area and
5 dialysis facilities is such that most of the under utilized
6 facilities are in distant counties and in more rural areas
7 more than thirty minutes away. These facilities are not
8 feasible alternatives for Crest Hill and Joliet residents.

9 Dialysis often leaves patients fatigued and
10 nauseous, and it can be a difficult trip home. You heard
11 from the one woman whose husband would pass out in the
12 driveway on the way home. Requiring patients to travel 30
13 to 45 minutes each way, three times a week, for dialysis is
14 an extreme hardship for both patients and their caregivers.
15 Requiring patients to use these under utilized facilities
16 is not appropriate access.

17 Also, because of early intervention, patients
18 have improved morbidity and mortality in the earlier stages
19 of CKD. This is causing, though, an increased need for
20 dialysis. A physician group that has identified a patient
21 base for this proposed facility is treating its patients at
22 heavily-utilized Joliet facilities. One of those
23 facilities is moving out of the Joliet city limits in -- to
24 the east and farther from Crest Hill at the end of the

1 year. Other approved projects are being developed to serve
2 a distinct base of patients who are not cared for by two
3 other different nephrology groups, and this group has a
4 significant number of patients beyond those who have been
5 identified to be treated at this facility. Those patients
6 will either remain at the other area facilities, and many
7 CKD patients who later require dialysis will also be
8 referred to other facilities to the extent space becomes
9 available over time.

10 Over the past three and a half years, HSA 9
11 has seen rapid growth in the number of ESRD patients. In
12 fact, the number of dialysis patients in this planning area
13 increased from 517 patients in January 2008 to 832 patients
14 in June of 2011. That's an average annual increase of
15 approximately 17 percent. While this might seem like a
16 public health crisis, it is partly a signal of the improved
17 intervention and treatment of pre-dialysis kidney problems.
18 In addition to increasing the number of patients, the
19 attrition rate for patients on dialysis are decreasing due
20 to improved treatment.

21 One of our greatest achievements at DaVita is
22 our nationwide impact program. We focus on reducing
23 patient mortality and morbidity during the first 90 days of
24 dialysis, which are the most important time frame, and we

1 do that through education and treatment. In addition to
2 that, we provide free programs called "Empower" around the
3 country and here in Chicago, where patients get education
4 on CKD and how to reduce their chances of needing to go on
5 dialysis sooner.

6 DaVita is a national provider. However, it
7 currently does not own or operate any dialysis facilities
8 in this area and does not have near the presence Fresenius
9 has in metropolitan Chicago. In metro Chicago, DaVita has
10 22 percent of the stations and Fresenius has 61 percent of
11 the stations, nearly three times what we have. In Will
12 County, though, DaVita has none. Fresenius has three
13 facilities, operating nearly half of the stations within
14 the county. Other than this project, it's been two years
15 since DaVita initiated a new dialysis facility in
16 metropolitan Chicago. We all know from being here every
17 hearing how many Fresenius brings to this Board. Please
18 understand, these facilities are small and they typically
19 serve significantly less than 100 patients at any
20 particular site. In this case, we will serve about 58
21 patients at any given time.

22 Approval of the Crest Hill facility will
23 increase competition in the area and give area patients
24 access to our innovative care models.

1 In response to Dr. Chawla's comments, I would
2 like to note that Dr. Chawla has objected to every recent
3 application for a new dialysis center in the Joliet area
4 and is using this process as an attempt to block
5 competition and improve his own bottom line. It's our
6 understanding that Dr. Chawla conservatively manages his
7 payor mix to minimize his exposure to Medicaid and charity
8 care. DaVita, on the other hand, accepts and dialyzes
9 patients with renal failure, needing a regular course of
10 dialysis, without regard to race, color, national origin,
11 gender, sexual orientation, age, religion, disability or
12 ability to pay.

13 The Board exists to determine whether need for
14 healthcare services exists, not to protect current
15 providers from competition that will increase access to the
16 most vulnerable populations and bring high quality and
17 innovative care to the area. Approval of the Crest Hill
18 facility will do exactly that and at the same time provide
19 choice to patients in the area with physicians that have a
20 transplant rate of 11 percent as compared to the 7 percent
21 national rate. Even taking into account Dr. Chawla's
22 objection, Sun Hill can accommodate less than 30 percent of
23 Crest Hill's projected patients. Therefore, a new dialysis
24 facility is needed to ensure dialysis is accessible to the

1 remaining 70 percent of the patients.

2 We respectfully request the Board approve this
3 application. We thank you for your time and consideration,
4 and at this time, I'm happy to answer any questions you may
5 have.

6 CHAIRMAN GALASSIE: Thank you.

7 I'd like to open it up to the Board for any
8 questions.

9 MR. SEWELL: Mike, what is the HSA 9 number up
10 to in terms of --

11 MR. CONSTANTINO: 72 excess.

12 CHAIRMAN GALASSIE: 72 excess in HSA 9?

13 MR. CONSTANTINO: Yes.

14 CHAIRMAN GALASSIE: Do we have a ballpark
15 what the population of HSA 9 is? I know it's a tough one.

16 MS. FRIEDMAN: I think I have it. Do you want
17 it?

18 CHAIRMAN GALASSIE: I would like it.

19 MS. FRIEDMAN: It was in our submission, and I
20 have to read it the way it was provided there.

21 So Will County is the urban county in the
22 area. That population is 677,560; Kankakee County is
23 113,000; Kendall, 115,000; and Grundy is just over 50,000.

24 CHAIRMAN GALASSIE: So, about 950,000 people

1 in that district, and we're seeing about 25 new per year.

2 Okay. Thank you very much.

3 Questions from Board members?

4 Yes, sir, Mr. Hayes?

5 MR. HAYES: I was just wondering, how would
6 this -- when you talk about excess and patients driving,
7 now in the HSA 9 area, we've approved a total of 17 new
8 stations, and how would that -- they, of course, would have
9 an effect as well.

10 MS. DAVIS: Well, Silver Cross with their
11 relocation will serve patients residing on the east side of
12 Joliet, Lockport, New Lenox. Crest Hill will serve
13 patients in Crest Hill and the west side of Joliet. FMC
14 Joliet, which is a 16-station facility approved in March,
15 it projects it will serve 41 patients by the end of the
16 first year and 95 patients, or 99 percent utilization, by
17 the end of its second year. Therefore, there will be no
18 capacity, and it's a distinct population at FMC Joliet.
19 There are two different nephrology groups. Their patients
20 will be coming from Germane Nephrology Associates, and our
21 facility would be getting patients from Northeast
22 Nephrology.

23 MR. HAYES: But the -- neither of these would
24 be helpful to patients, the excess, in scheduling or time

1 wise?

2 MS. DAVIS: We believe not, especially with
3 FMC projecting it will be at 99 percent by two years. The
4 Plainfield facility reached 94 percent utilization within
5 18 months. There's truly a growing need in these
6 communities as these facilities are built, and it's not
7 like you build -- you know, one of my favorite things is
8 not -- you build an MRI center, so doctors are going to
9 order more MRI's. Patients are going to dialysis. They
10 can't be referred to dialysis unless they really need it
11 and, obviously, we're seeing more and more patients that
12 need dialysis.

13 MS. FRIEDMAN: If I can note one thing about
14 the Board's rules -- and they were recently changed -- it
15 provides assurances to the Board that the patients, ESRD
16 patients that are being committed to a project have not
17 been counted for support in another project, and we've got
18 the distinction of different physician practices that helps
19 in some of these instances to demonstrate these are
20 different patients, and it's a lot different than a
21 hospital projection where you might look at the physicians'
22 historical referral patterns. They don't identify patients
23 by zip code and initials. Here we know exactly what
24 patients are entering renal failure.

1 MR. HAYES: Thank you.

2 CHAIRMAN GALASSIE: Thank you.

3 Other questions by Board members?

4 (Pause)

5 CHAIRMAN GALASSIE: Hearing none, I'm going
6 to make a motion -- may I have a motion to approve Project
7 11-004 for the establishment of a 12-station ESRD facility
8 in Crest Hill, Illinois?

9 MR. HILGENBRINK: So move.

10 MR. GREIMAN: Second.

11 CHAIRMAN GALASSIE: Moved and seconded. I
12 will ask for a roll call vote, please.

13 MR. DART: Motion made by Mr. Hilgenbrink,
14 seconded by Justice Greiman.

15 Dr. Burden?

16 (No response)

17 CHAIRMAN GALASSIE: Dr. Burden had to step
18 out and is no longer participating in the meeting as of
19 about 10 minutes ago. Thank you.

20 MR. DART: Mr. Eaker?

21 MR. EAKER: I don't believe I've heard
22 anything today that would change my vote from last time. I
23 vote no.

24 MR. DART: Justice Greiman?

1 MR. GREIMAN: Aye.

2 MR. DART: Mr. Hayes?

3 MR. HAYES: I haven't heard anything new
4 either, and I think with the excess capacity in HSA 9, I'm
5 going to vote no.

6 MR. DART: Mr. Hilgenbrink?

7 MR. HILGENBRINK: I support the access and
8 choice, so I'm going to vote yes.

9 MR. DART: Ms. Olson?

10 MS. OLSON: I don't know what to do. I mean,
11 do we stop when we have one within three miles of
12 everybody's house? I don't know.

13 CHAIRMAN GALASSIE: You can abstain, vote yes
14 or vote no.

15 MS. OLSON: Abstain.

16 CHAIRMAN GALASSIE: Thank you.

17 MR. DART: Mr. Sewell?

18 MR. SEWELL: No. Excess capacity.

19 MR. DART: Chairman Galassie?

20 CHAIRMAN GALASSIE: Despite the compelling
21 testimony and including Uncle Dan specifically, and I
22 regret, but I too must advise it's evolving to an ESRD
23 facility next to every McDonald's, and I understand the
24 difficulty for some folks, but I find myself, based on the

1 data, of having to vote no.

2 MR. DART: That's two ayes, four negatives.

3 CHAIRMAN GALASSIE: Motion does not pass.

4 Thank you. Good luck.

5 Okay. I'm he going to move forward. We have
6 three or four quick pieces of information and then a very
7 brief Executive Session, and I'll ask everyone, other than
8 Board members, to leave.

9 Do we have a motion that we need to file,
10 Frank?

11 MR. URSO: This is based upon the follow-up on
12 the discussion that we had earlier. This is a motion to
13 approve a Final Order on Advanced Eye Surgery Laser Center,
14 which was Project 04-03, HFBP 0702, requesting a Final
15 Order.

16 CHAIRMAN GALASSIE: Do we have a motion to --
17 accept or approve?

18 MR. URSO: Approve.

19 CHAIRMAN GALASSIE: -- approve that Final
20 Order?

21 MR. EAKER: So moved.

22 MS. OLSON: Second.

23 CHAIRMAN GALASSIE: Moved, seconded. Roll,
24 please.

1 MR. DART: Motion made by Mr. Eaker, second by
2 Mr. Olson.
3 Mr. Eaker?
4 MR. EAKER: Yes.
5 MR. DART: Justice Greiman?
6 MR. GREIMAN: Yes.
7 MR. DART: Mr. Hayes?
8 MR. HAYES: Yes.
9 MR. DART: Mr. Hilgenbrink?
10 MR. HILGENBRINK: Yes.
11 MR. DART: Ms. Olson?
12 MS. OLSON: Yes.
13 MR. DART: Mr. Sewell?
14 MR. SEWELL: Yes.
15 MR. DART: Chairman Galassie?
16 CHAIRMAN GALASSIE: Yes. Motion passes.
17 Thank you very much.
18 Claire, our Rule Coordinator, is here, and,
19 Claire, we shifted the agenda, as I'm sure you know,
20 yesterday, so your area was covered. But you've been here
21 all day. If there is any comments you wanted to add, we're
22 happy to give you that opportunity. If not, thank you for
23 being here.
24 MS. BERMAN: I'm sure it was fully covered,

1 and I'm assuming, because I did not hear the full detail
2 about the birthing center piece, that that was up for your
3 review and it was approved.

4 CHAIRMAN GALASSIE: The answer I'm being told
5 is yes. Thank you. We're glad you're here.

6 Also, before we break, I want to thank
7 Courtney and Cathy for the coordination of the facility
8 here. It's been very comfortable, and lunch. We
9 appreciate both of your efforts for the last two days.

10 I would now, unless --

11 MR. CARVALHO: Two quick things. Claire,
12 because Richard Sewell and I will both have someone jumping
13 at our ankles about the birthing center thing, what does
14 that mean in terms of the time from this point forward?

15 MS. BERMAN: Well, now that I have approval of
16 the response to public comment, I can finish up the rest of
17 the paperwork for Second Notice. There's First Notice,
18 Second Notice, and then there's Rule Adoption, hopefully,
19 after the Joint Committee on Administrative Rules does
20 their thing. So, I would say maybe another four or five
21 weeks.

22 MR. CARVALHO: Four or five weeks until what?

23 MS. BERMAN: Well, it would be then reviewed
24 at the JCAR meeting. This is October -- I don't know if I

1 can get it done in time for their November meeting, because
2 I don't know their deadline yet, but at the latest, it
3 would be the December JCAR meeting, which is the second
4 Tuesday of the month.

5 MR. CARVALHO: And then after JCAR, assuming
6 they approve it --

7 MS. BERMAN: Then it's maybe a week's worth of
8 more forms and then it's filed and it's in effect.

9 MR. CARVALHO: Probably by the end of the
10 year?

11 MS. BERMAN: Yes.

12 CHAIRMAN GALASSIE: It doesn't go back to the
13 Legislature?

14 MS. BERMAN: No.

15 MS. AVERY: We have the draft application
16 prepared.

17 MR. CARVALHO: Yes, that's the other question.
18 The second thing, yesterday there was a memo about
19 legislation. Is there a draft of the legislation
20 available?

21 MS. AVERY: We don't have a bill name until --

22 MR. URSO: I'll get a copy of what we have
23 available.

24 MR. CARVALHO: That would be great. Thank

1 you.

2 CHAIRMAN GALASSIE: Thank you.

3 Ladies and gentlemen, I would ask that you be
4 timely in emptying the room. We're going to go into
5 Executive Session. Everyone other than Board members,
6 please take off.

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8 EXECUTIVE SESSION HELD

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10 MEETING ADJOURNED AT 3:36 P.M.

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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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