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HEALTH FACILITIES &
SERVICES REVIEW BOARD

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

OPEN SESSION

SEPTEMBER 12, 2012

ORIGINAL

STATE OF ILLINOIS

HEALTH FACILITIES AND SERVICES REVIEW BOARD

525 West Jefferson Street, 2nd Floor

Springfield, Illinois 62761

217-782-3516

OPEN SESSION

(September 12, 2012)

Regular session of the meeting of the State of Illinois Health Facilities and Services Review Board was held on September 11 and 12, 2012, at the Marriott Bloomington-Normal Hotel & Conference Center, 201 Broadway Street, Normal, Illinois.

PRESENT:

Dale Galassie - Chairman (present September 11 only)
John Hayes - Vice-Chairman (presided on September 12)
Ronald Eaker
James Burden
Alan Greiman
Kathy Olson
Richard Sewell
David Penn
Deanna Demuzio

ALSO PRESENT:

Courtney Avery - Administrator
Catherine Clark - Board Staff
Frank Urso - General Counsel
Juan Morado - Assistant Counsel
Alexis Kendrick - Board Staff
Claire Burman - Board Staff
Michael Constantino - IDPH Staff
George Roate - IDPH Staff
David Carvalho - IDPH
Bill Dart - IDPH
Michael C. Jones - DHFS
Michael Pelletier - DHS (present September 11 only)
Bonnie Hills - IDPH Staff (present September 11 only)

Reported by:
Karen K. Keim
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START TIME: 10:05 A.M.

VICE-CHAIRMAN HAYES: I'd like to call the meeting of the Health Facilities and Services Review Board, the second day of our meeting, on September 12th of 2012, and I'd like to first be able to take a moment of -- in any way you want to, to be able to remember our diplomatic staff in Libya. So, if I could just have a couple moments of silence.

(Pause)

VICE-CHAIRMAN HAYES: Thank you very much.

I would like to be able to take -- George or Mike, would you like to take a roll call?

MR. ROATE: Roll call.

Dr. Burden?

MR. BURDEN: Here.

MR. ROATE: Senator Demuzio?

MS. DEMUZIO: Here.

MR. ROATE: Mr. Eaker?

MR. EAKER: Here.

MR. ROATE: Justice Greiman?

JUSTICE GREIMAN: Here.

MR. ROATE: Mr. Hayes?

VICE-CHAIRMAN HAYES: Here.

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MR. ROATE: Ms. Olson?

MS. OLSON: Here.

MR. ROATE: Mr. Penn?

MR. PENN: Here.

MR. ROATE: Mr. Sewell?

MR. SEWELL: Here.

MR. ROATE: And Chairman Galassie is absent. Eight members present.

VICE-CHAIRMAN HAYES: Okay. Thank you.

Well, I'd like to be able to go into our agenda right away. We have a busy day today, and we are on Item E, Permit Renewal Requests, and Project 08-084, Pleasant View, Ottawa, and that project has been deferred. Item F on our agenda -- excuse me. Project 08-084, Pleasant View, Ottawa, has been withdrawn.

So, Item F on the agenda, Alteration Requests, and this is Project 09-068, Pinckneyville Community Hospital, Pinckneyville. Do we have any public comment on this?

(Pause)

VICE-CHAIRMAN HAYES: Seeing no public comment, could I invite the Pinckneyville Community Hospital representatives of the applicants to the table?

(Pause)

VICE-CHAIRMAN HAYES: Could you state your name and spell it for the Court Reporter?

MR. HUDGINS: Yes.

VICE-CHAIRMAN HAYES: And then we'll have you sworn in.

MR. HUDGINS: Yes. My name is Thomas Hudgins. I provided her with a card for the spelling. I'm the CEO of Pinckneyville, Illinois Hospital and District.

MR. PARKHURST: Ed Parkhurst, Prism Healthcare Consulting, consultants to Pinckneyville.

VICE-CHAIRMAN HAYES: Okay. Can I have a -- Mike, can we have a Staff report?

MR. CONSTANTINO: Thank you, Mr. Chairman.

The applicants are proposing an alteration to Permit No. 09-068, Pinckneyville Community Hospital. This is the first permit alteration for this project. Essentially, the applicants are asking to reduce the cost by approximately $15.5 million and reduce the gross square footage.

Thank you, Mr. Chairman.

VICE-CHAIRMAN HAYES: Okay. Go ahead.

MR. HUDGINS: Yes, thank you. My name is Tom Hudgins. I'm the CEO of the hospital and district. We're a critical access hospital, a necessary provider by the

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Department of Public Health. I appreciate the opportunity to come here today and appreciate the Staff's assistance with putting the alteration together.

We were here six weeks ago, getting an extension, which has now brought us the ability to come back and ask ability to reduce the scope of our project to help us in pursuing funding through the USDA. We would like to reduce it by 8 beds, 25 to 17. The gross square footage will drop 21 percent, which is the beds to relocate the outpatient rehab to the new campus to possibly some date in the future. As indicated, we dropped $15 million out of the project from the original number several years ago.

We're working with USDA to get a Community Direct Loan from them. We're in the process of working with them on some questions they have raised. We meet with them again on the 26th. We're going to provide them written answers next week and sit down and see what other questions they have at this point.

There are a couple of things that were noted in the report that I'd like to speak to briefly and we did supply a written comment on. The cost per square feet has come out a little higher than what was expected, I think, in the outline from the SAR, but we have dropped the

project costs per square foot significantly. We've dropped about $25 a square foot from the original project request, and we think the resulting number shows the clinical is a little higher. It is actually an allocation that would take a lot of work to go through and work out, but I think the fact that we've been able to reduce the project significantly in square footage costs speaks to our efforts to make this work.

Another high number is our architectural engineering fees. They're going to be a little higher than what typically is seen, and if you stop and think, we've had to do some redesign on the project to shrink it, so when we take it to IDPH, they will give us the necessary green light to go ahead with construction. That's what has driven that particular piece of our expenses being a little higher in that area. But, on the other hand, they're not significantly higher.

Again, I'd like to thank the Board for the opportunity to come in and put this alteration request in front of you so we can continue to pursue developing this project for the community and maintain access to care and help maintain jobs on the part of the City, where the economy is still disrupted.

I'd be happy to take any questions you have.

VICE-CHAIRMAN HAYES: Any questions from the Board?

MR. BURDEN: I'm asking only regarding the U.S. Department of Agriculture loan. It appears you're not able to provide us evidence that you secured that. Does that look likely? Does it look difficult? Is it something you expect to secure?

MR. HUDGINS: At this point, we're expecting we'll be able to secure it. The question that came back to us has nothing to do with the financial feasibility of the project. They were looking more at questions on our current operations and how we are operating compared to other facilities of our size. I think between some information we have locally and some recent available national information on the performance of critical access hospitals, where we compare very favorably, we will be able to convince the people in the Champaign office and then in the Washington office this is a viable project. They didn't ask us anything about a financial feasibility study. I think they're more concerned -- making sure that we've done our due diligence to make sure the facility is operating appropriately and that we'll be able, as they said, to make the payments when they come due.

MR. BURDEN: Mr. Constantino, Michael, can we

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presume and evaluate this application on the presumption that the USDA is forthcoming?

MR. CONSTANTINO: All we have right now is what the applicants have told us regarding the USDA loan commitment.

MR. BURDEN: In our rules and regs, are we allowed to approve this application with the presumptive expectancy of securing this loan, which is significant?

MR. CONSTANTINO: You've approved other projects which have had negative findings in the past, yes.

MR. BURDEN: Thank you.

MR. HUDGINS: Obviously, if the USDA financing does not come through, then the project will not move forward, but at this point, the signals we are getting from them are positive at this point.

VICE-CHAIRMAN HAYES: Mr. Sewell?

MR. SEWELL: Yes. I want you to clarify again this call for square foot issue. You're saying -- well, the State Agency Report says that you exceeded that for new construction -- or for construction. You're saying, though, that you've made alterations that reduce the overall project costs per square foot and that with a lot of analytical work, you could probably pull out what now the clinical costs per square foot is. But have you done

that, and does that make it, you know, consistent with State standards?

MR. HUDGINS: That's why I made the comment. On the overall cost per square foot, we've dropped significantly with some of the things we took out. For instance, when we took out the new wing with the beds that we're not going to build and some other spaces that we shrank down, some of the other spaces that are in there that support our outpatient services, which are 85 percent of what we do, are driving the fact that our costs on the clinical square footage is a little higher. The whole project is lower. I think that's just a reflection of the shift in healthcare away from beds and to outpatient settings, with more space in the lab, your imaging departments, your specialty clinics, to be able to accommodate people coming through. As we look at it, that's where we see the difference, is that, and I don't know when the -- what the clinical square footage numbers are based on historically, but with the acceleration in outpatient services, I think you're going to see a shift in the future with maybe a little more cost to make the outpatient work. But that's where healthcare is going, treating people that walk in and walk out.

MR. SEWELL: Another question for Mike. Our

standard is for new construction, and contingencies is for just the clinical part of the project?

MR. CONSTANTINO: That's correct. When the Board originally approved this project, that became the new State standard.

MR. SEWELL: I see.

MR. CONSTANTINO: And it is just for the clinical portion.

VICE-CHAIRMAN HAYES: Senator Demuzio?

MS. DEMUZIO: Thank you, Mr. Chairman.

I see that you made a -- did you do an application to HUD?

MR. HUDGINS: Yes.

MS. DEMUZIO: And can you tell us what happened from your change from the HUD 242 program to the USDA?

MR. HUDGINS: We were under the impression HUD was going to fund the project, and at the end, as HUD looked at it, they had -- as we understood it, in May of the year we got denied, had put in their own determination of whether the project was necessary or not, even though we had got the Certificate of Need from the State of Illinois, and in their looking at it, I guess their criteria -- they came back and made a determination on their criteria that

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was contrary to what Health Facilities Board had done in its review and felt that, you know, the project might not be necessary in the area, even though we had a positive financial finding and we had a Certificate of Need, all the things we thought we had to do, and that was a bit of a surprise.

MS. DEMUZIO: So what year was this? How long have you been working on this?

MR. HUDGINS: Actually, the board and hospital started on this in the fall of 2002, in terms of working through looking at what are the options for the future, and we were before the Board a number of years ago. We had to close a nursing home unit that was causing financial difficulties and relocated the residents to other area nursing homes. It's been a very deliberate process to try to work through this, and, like I said, we thought we had HUD ready to finance the project, but at the last minute, they went another direction. USDA, however, has been very receptive to us at this point on the project and its need in the rural community.

MS. DEMUZIO: But your original figure with HUD was at your 25-bed? Is that what it was? And it's only been with USDA that you dropped that total down to 17?

MR. HUDGINS: Yeah. We looked at it and,

again, maybe it's good fortune that as things have shifted in healthcare, we've seen how our beds are utilized. So now we can take the expense of those beds out. The structure, if for some reason was needed in the future, would allow it to come back on, but we'd have to come back for approval to do that.

MS. DEMUZIO: Thank you.

VICE-CHAIRMAN HAYES: Member Penn?

MR. PENN: This is kind of a follow-up question, financing. This comes in front of this Board often where I feel uncomfortable approving an application when we don't have finances in place. I don't know if we have any power in this chicken and egg theory. They should get the financing first before they come before this Board, because, again, if we approve the application and give the go-ahead and then finance is not there, there's other hurdles you'll have to face for this Board. So, what I'm saying, hospitals and financing are starting to rely on USDA. I'm not sure if that's always the best way to go, but, as Mike said, we have approved it in the past. But I'm also concerned about approving things when finance is not really in place. So, I don't -- maybe it's more of a question for Claire. Do we have any way to make sure the financing is in place before they come in front of this

Board?

MS. BURMAN: We would have to relook at the Rules for financial review and make sure that addresses it specifically.

MR. PENN: Would it be easier for the applicant, when they come here, that we know financing is in place and we can give the approval or denial based on the --

MS. BURMAN: I imagine it would be easier. I don't know how easy it is to obtain that.

MR. HUDGINS: If I could, we were here at the last meeting, asking for an extension to allow us to continue to work with HUD, because our project -- with USDA -- I'm sorry -- because we were looking at the permit expiring on October 20th. It is a very -- it's a deliberate process. It doesn't happen quickly, and the thing the alteration would allow us to do is turn and start work with IDPH on getting the drawings done, because when we get to the end of the USDA project, they have to have a (unintelligible) price to consider this. In order to get that, we have to alter our drawings and run them through IDPH. Maybe it's a little bit of a chicken and egg thing. We're trying to figure out what type of chicken it might be, but this would enable us to then go to IDPH and say,

"We've gotten the okay to alter the size of the project." Otherwise, we would be working on that, we might come back here with something that then there would be more questions, additional delays in this. As I indicated if USDA does not work for us, then I doubt you'll see us back here looking for anything further on this project, because in today's market, in particular for rural hospitals, USDA is kind of the source they go to. The commercial markets are just a little leery right now, whereas USDA, because of their focus in rural -- helping rural communities maintain local services, have a little better understanding, I think, than some of the others do, or are more open to working with us.

MR. PENN: I visited the Pinkneyville site, and I have seen the condition of the properties, and what I'm concerned about is not the brick and mortar. I'm concerned with the services in the facility that we provide for the patients, services that are needed in that area, and how quickly we can get those services provided for the residents of that Service Area. So, this seems to be a slow process, going to USDA and so forth, during that time while services are not being provided.

MR. HUDGINS: We're still maintaining the services at our existing facility and I'll give credit to

the staff for working under the conditions they are, and they're making it work. It's just very awkward and inconvenient, and our growth has caused us problems. Most critical access hospitals are 70 percent outpatient, 30 percent inpatient. We're 85/15 and continuing to grow.

In terms of the services we're able to bring right now, we're covering every need that we can get someone to come in town and take care of. The issue is the physical plant, and you had a look at it a few years ago. It's getting to the point where we're having challenges in keeping it running, and we can't -- we're in a position where we can't go horizontal. If we could go horizontal, we would go in a different direction, but we are extremely landlocked in the downtown area and want to move to a location where we can set our services up so they are provided in a convenient fashion in the community, that they can look to us rather than thinking about traveling, and have adequate space, as other technologies and services become available, to bring them into the community so folks won't have to travel. A lot of them don't like to drive very far, and I keep going back -- we're the largest employer in the county, and with the unemployment rate still above 10 percent and median incomes are below the State average, we're working very hard to maintain the

presence of the facility for both of those reasons, access to care and continue to be part of the economic engine in the future.

MR. PENN: I just think if we went back and revisit those rules, we could fasttrack some of those applications and get you what you need and the people in your community what they need as well.

MR. BURDEN: Yesterday we had the financial officer from Jackson County explain to us the dire circumstances of the entire county. You mentioned closing the nursing home. We approved closure of another nursing home in the southern part of your county. It appears that all of us are very concerned about what you're attempting to do, but based on what we heard yesterday, coupled with your comments today, things are in dire shape in the county, and I'm very hopeful that you get the financing you need, because we all agree, it certainly seems to be essential to your community, but there are problems that we heard about yesterday that were significant in terms of financing.

MR. HUDGINS: There are challenges, but we have been at this for almost 10 years. We're not going to back down.

MR. PENN: How close are you to Jackson

County?

MR. HUDGINS: They're the next county south of us.

VICE-CHAIRMAN HAYES: Mike, can you make a comment on having the financing in place before coming before the Board for approval?

MR. CONSTANTINO: Yeah. This -- we've taken another look at this. In the past, we accepted the attestation from the applicants that they would get a USDA loan or a HUD loan, and we just accepted that and we were positive on the criteria. But once the market has changed -- as all of us know, the financial conditions have changed -- we found that a lot of these -- not a lot. Some of these projects have told us they were going to get HUD financing and it did not take place. They were denied. So what we've done is, when we come to that availability of funds, we're telling the Board that we do not have a loan commitment from the USDA or HUD. That's what that means. The Board has approved these projects in the past, like the applicants have stated. At the last meeting you did give them a second extension of obligation to give them additional time to get the HUD -- to get the USDA loan. So, it is not -- this is something due to the changes in the marketplace. Our rules currently do not accommodate

this. We're just looking at it differently now. That's why the finding was negative.

MS. OLSON: I have a question, a quick question. What is the amount of the USDA loan?

MR. HUDGINS: We're asking for $22.7 million.

MS. OLSON: Okay. So that's -- if I do the math right -- and math has never been my strong suit -- even with all of the TIF and the IDPH, you're still short.

MR. HUDGINS: No. We have money invested already. The initial roughly $9 million -- some of that is reflected in architectural fees -- we've already expended for acquisition of property and those kinds of things. We have cash on hand to cover our obligation and still leave us with about two and a half million cash, back for operations and the unexpected.

MS. OLSON: Okay. Thank you.

MR. URSO: Mr. Penn, maybe to answer your question, if it's impossible for this applicant to get a permit to complete the project, then they should notify the Board, as they -- timely notify the Board that they need to abandon the project or relinquish it, as we call it. They should not be subject to any sanctions or penalties, as long as they keep the Board in the loop as far as what's going on.

MR. PENN: Thank you.

MR. URSO: And the other question I have for the applicant, is your status as the critical access hospital in any way jeopardized by these alterations that you're talking about?

MR. HUDGINS: Sorry?

MR. URSO: What's the impact of these alterations on your status?

MR. HUDGINS: It will have no impact. We will just be moving to a new location, which is permitted under the rules with CMS, and we'll still be a critical access hospital. We'll continue to provide the current services. We anticipate no changes in our staffing. In time, staffing will grow, as we have more services, but we're physically moving 1.8 miles to a bare piece of ground and putting up a building to accommodate who we really are today and give us the ability, should we need to change and grow. Any of the areas that might grow in the future have an outside wall and the ability go horizontal and accommodate changes in the future. We're trying to make this an investment that has a minimum of 50-year life in the community, if not longer.

MR. URSO: Thank you.

VICE-CHAIRMAN HAYES: All right. I'd like

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to -- I don't see any other questions from the Board. What I'd like to do now is have a -- may I have a motion to approve a permit alteration for Pinckneyville Community Hospital in Pinckneyville, Illinois?

MS. DEMUZIO: So moved.

MR. SEWELL: Second.

MR. ROATE: Motion made by Senator Demuzio, seconded by Mr. Sewell.

Dr. Burden?

MR. BURDEN: Yes.

MR. ROATE: Senator Demuzio?

MS. DEMUZIO: Yes.

MR. ROATE: Mr. Eaker?

MR. EAKER: Yes.

MR. ROATE: Justice Greiman?

MR. GREIMAN: Yes.

MR. ROATE: Ms. Olson?

MS. OLSON: Yes.

MR. ROATE: Mr. Penn?

MR. PENN: Yes.

MR. ROATE: Mr. Sewell?

MR. SEWELL: Yes.

MR. ROATE: Chairman Hayes?

VICE-CHAIRMAN HAYES: Yes.

MR. ROATE: That's eight votes in the affirmative.

VICE-CHAIRMAN HAYES: Motion passes.

Now, let's go -- the next item on our agenda is the -- is Project 10-015, Gold Coast Surgicenter in Chicago. Now, I understand that -- is there somebody from Gold Coast here?

MR. SILBERMAN: Yes.

VICE-CHAIRMAN HAYES: And would you like to make a presentation?

MR. SILBERMAN: Not at all. I'm just here if the Board or any members of the Staff had any questions.

VICE-CHAIRMAN HAYES: Okay. So, Mike, can you do your Staff report?

MR. CONSTANTINO: Thank you, Mr. Chairman.

On June -- in June of 2010, the permit holders were approved for a change of ownership. As part of that change of ownership, there was a condition placed on the permit. The permit holders were required to report quarterly to you on the compliance with the Cancer Registry and life safety issues. We are requesting -- the State Board Staff is requesting the Board to remove that condition now, because they have complied with all of the requirements and we have mechanisms in place to verify that

they are in compliance with the Cancer Registry and life safety issues. So, this is a request by the Board Staff to remove that condition.

Thank you, Mr. Chairman.

VICE-CHAIRMAN HAYES: Can we have the applicant sworn in.

(Oath given)

VICE-CHAIRMAN HAYES: Do we have any Board questions?

(Pause)

VICE-CHAIRMAN HAYES: Well, seeing none, I'd like to move to a motion.

MS. OLSON: So moved.

VICE-CHAIRMAN HAYES: This is a motion for Project 10-015, Gold Coast Surgicenter, and this is to remove the conditional and contingent permit -- reports on conditional and contingent permits. Can I have a motion?

MS. OLSON: So moved.

MR. EAKER: Second.

MR. ROATE: Motion made by Ms. Olson, seconded by Mr. Eaker.

Dr. Burden?

MR. BURDEN: Yes.

MR. ROATE: Senator Demuzio?

MS. DEMUZIO: Yes.

MR. ROATE: Mr. Eaker?

MR. EAKER: Yes.

MR. ROATE: Justice Greiman?

MR. GREIMAN: Yes.

MR. ROATE: Ms. Olson?

MS. OLSON: Yes.

MR. ROATE: Mr. Penn?

MR. PENN: Yes.

MR. ROATE: Mr. Sewell?

MR. SEWELL: Yes.

MR. ROATE: Chairman Hayes?

VICE-CHAIRMAN HAYES: Yes.

MR. ROATE: Eight votes in the affirmative.

VICE-CHAIRMAN HAYES: Motion passes.

MR. CONSTANTINO: Mr. Chairman, Cathy will be around to pick up these State Agency Reports from the Board members, if you would give them to Cathy. There was an attachment on those reports.

(Pause)

VICE-CHAIRMAN HAYES: I appreciate the Board members' assistance in collecting this information from the State Agency Reports.

Okay. What I'd like to do now is

Applicants -- Item D now, Applications Subsequent to Initial Review, and the first is D-13, Project 12-060, Singer Mental Health Center, Rockford, and I understand there is public comment here. I'd like to have Juan describe the information for public comment.

I understand we have 17 people for public comment, and what we'll do is, we'll call them in groups of 6, and we'll alternate between support and opposition.

Juan?

MR. MORADO: The Open Meetings Act requires that any person shall be permitted an opportunity to address public officials under the rules established and accorded by the public body. The following is the procedure which the Illinois Health Facilities and Services Review Board will adhere to:

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

So that the Board is able to accomplish other agenda items, each speaker will be allowed a maximum of two minutes to provide their comments. I will be signaling when you have thirty seconds left and when you should conclude your comments.

Inflammatory or derogatory comments are prohibited. No more than three persons representing the same organization are allowed to provide testimony regarding the same project. Public comment for each speaker is limited to testimony for one project or issue. The Board asks that you please make sure that all comments are focused and relevant to the specific project on the current agenda. Comments should not be repetitive and not be disruptive to the Board's proceedings. The public is strongly urged to participate in the long-standing opportunity for written and oral comment provided by the public hearings conducted for CON projects under review, as well as direct rule making. Scheduled public hearings are posted on the Health Facilities and Services Review web site.

Speakers who cannot comply with these guidelines will not be allowed to provide a comment at the Board's open meeting. Please note that the -- anyone wanting to provide public participation comments at a Board

meeting must pre-register, and the only time to pre-register was 30 minutes before this Board meeting began.

Thank you.

VICE-CHAIRMAN HAYES: Thank you, Assistant Counsel Morado.

Now I'd like to call up Michael Flora, and he is in support of the project; John Cabello, who is in opposition. And please come to the table at the front here. Richard Kunnert, who is involved in the support of the project; Howard S. Paul, M.D., who is in opposition; Phillip Eaton, who is a supporter of the project; and Michael Butterworth -- I hope I pronounced that right. He's in opposition. Is Michael Butterworth here? Butterworth?

MR. BUTTERWORTH: I submitted written comments already.

MS. AVERY: I want to specify that even though you submitted your written comments, the Board has no way to get those distributed and read today. So, if you want the Board to know, I would suggest that you read into the record your comments for today or have someone to do it for you. Did you need the copy back?

MR. BUTTERWORTH: That's okay.

VICE-CHAIRMAN HAYES: Thank you.

Now, I understand that you don't have to be sworn in, so why don't we start out with Michael Flora.

MR. FLORA: Good morning. My name is Michael Flora (spells name).

Early in the decision-making process to seek closure for Singer Mental Health Center, the leadership of the Department of Human Services, Division of Mental Health, informed providers in the region to begin the planning process. The regional providers also have been meeting and developing a coordinated plan to assist in the potential closure of Singer Mental Heath Center to assist in the provision of a continuum of care for those we serve.

Behavioral healthcare is an essential part of healthy communities. Each year, more and more Americans are in need of mental health and substance abuse services. For over 40 years, Ben Gordon Center has been providing a full continuum of quality outpatient behavioral healthcare services for adult, children, and families in Illinois. We have seen a trend over the past several years of increased demand in outpatient mental health and substance abuse services at the Ben Gordon Center. Since FY '01, we've had a 300 percent increase in the numbers of persons served annually.

As our community has grown, so have our programs and services to meet those community needs. We believe that the best care happens in our local community, where individuals have access to their support system, their families, and caring professionals, and have access to the after-care options available after the completion of inpatient care. Our role is to provide a continuum of outpatient care in our community. The Ben Gordon Center offers that full continuum. Part of that continuum includes emergency mental health services. These services range from a crisis response line, 24 hours a day, 7 days a week, where individuals are provided an opportunity to talk with a counselor any time, or walk in for services as needed, as well as pre-hospitalization screening for those most in need.

From Fiscal Year '06 to FY12, we have experienced a 122 percent increase in the number of crisis calls. Offering a full continuum of crisis services in our region is essential in meeting the needs of our safety net providers. The plan put forth by the Division of Mental Health addresses those needs, and we are in support of that plan. We have worked in partnership with the Division of Mental Health to develop a plan to meet the community's need. This plan has involved consumers and families,

agencies, and other community stakeholders.

As part of this plan, the Ben Gordon Center will expand services for those in acute crisis by adding professionals and programs, such as intensive outpatient program --

MR. MORADO: Thirty seconds.

MR. FLORA: -- a community support team, and an additional fulltime psychiatrist in a living room model. We have had a good, professional, working relationship with the Division of Mental Health over the years, and we support the plan for the rebalancing of the resources put forth by the Division of Mental Health and stand ready to work in cooperation with our community of providers, stakeholders, to benefit our community.

Thank you.

VICE-CHAIRMAN HAYES: Thank you. And Mr. Flora was in support of the project.

Now, can we go to John Cabello? And he is in opposition.

MR. CABELLO: Good morning. John Cabello (spells name). I happen to be the State Representative of the 68th District, and I appreciate Dr. Burden earlier talking about the devastation that this will cause our community. I also happen to be a detective with the

largest police agency in the county, and I see firsthand the problems that this will cause. We've had, unfortunately, folks slip through the cracks already. This is going to cause more people to slip through the cracks. When people slip through the cracks, we haven't done our jobs. If we don't do our jobs like we're supposed to do, then we have fundamentally made huge mistakes.

We see that there are not enough services in our community. We see that our community is crime-ridden, and we don't have the help that we need. Closing Singer Mental Health Center is going to devastate our community further, not only because of the economic issues, but because more people will fall through the cracks. Somebody needs to be held responsible for those folks falling through the cracks. There will be more accountability. I promise that. But this decision should be very easy, because they are already funded through Fiscal Year '13, and until there is a clear-cut plan, we cannot do this. I have asked and asked and asked --

MR. MORADO: Thirty seconds.

MR. CABELLO: -- for the clear-cut plan, and I have not received it. That angers me very much, because people's lives are at stake.

I appreciate the opportunity to speak with you

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today.

VICE-CHAIRMAN HAYES: Thank you, Representative.

Our next speaker in support of the project will be Richard Kunnert.

MR. KUNNERT: Richard Kunnert (spells last name). I'm here as a representative of the Mental Health Association in the Rock River Valley. I'm also former Superintendent of Singer Mental Health Center for eleven years. I spent -- prior to my superintendency, I spent 15 years working with community programs, developing programs for serious mentally ill people.

I support the Division of the Mental Health's request to close Singer, because Singer is no longer able to do the clinical mission that it performed for over 30 years. In the 1960's to the 1990's, Singer had 180 beds for the adult services. Now, if you take -- it has 50 beds, but 30 are assigned forensic. Therefore, it's serving 23 counties with essentially 20 general admission beds.

There is an alternative plan. I was able to be part of that coalition of agencies that came together to develop a community alternative in case that Singer closed, and I will tell you from my experience that the plan

submitted to the Division of Mental Health represented one of the most cooperative, collaborative, and creative that I have ever seen. For the first time, for example, within the history of our community, community hospitals were part of the equation in planning for alternatives within the community, and so, the plan that was submitted really did represent both services from the least restrictive --

MR. MORADO: Thirty seconds.

MR. KUNNERT: -- to the most restrictive, including inpatient care.

Thank you.

VICE-CHAIRMAN HAYES: Thank you.

Our next in opposition will be Howard S. Paul, M.D.

MR. PAUL: Thank you. I am a psychiatrist and have worked at Singer Mental Health Center for the past 12 years. This past year, I have been the Acting Medical Director for significant periods of time.

I think most people here already know of the severe psychiatric bed shortages in this country and in Illinois. At Singer, we have a 76-patient capacity, and we're often in overflow at 79 patients before the threat of this closure. Since then, the State has reduced our capacity, our patient capacity to 44 as of now.

Due to hiring freezes, attrition, as well as relocation of some staff, the DMH, Department of Mental Health administration, has warned that Singer will close sooner or later. I've been personally warned that if we stay open, the work will become even more difficult than it is now, because of the inactivity in hiring new employees. The DMH and the Governor's office are responsible for this callous indifference to the needs of staff at Singer Mental Health Center.

MR. MORADO: Thirty seconds.

MR. PAUL: If you think about it, how could they possibly be looking out for the best interests of the patients that we serve.

Thank you.

VICE-CHAIRMAN HAYES: Thank you, Doctor.

Our next speaker will be Phillip Eaton, and he'll be in support.

MR. EATON: Phillip Eaton (spells name). I'm the President and CEO of the Rosecrance Health Network, the largest provider of community mental health services in northwestern Illinois. I am here today to advocate for a better system of care for individuals in our region who suffer from mental illness. I speak on behalf of Rosecrance clients, many of whom have used the services at

Singer Mental Health Center through the years.

Increasingly, Singer has been unable to meet the needs, and too many people in psychiatric crisis have languished in jails or emergency rooms, waiting for appropriate care elsewhere. I am here to tell you today that Singer should close. We have a plan to create a new service model, to provide a more responsive, robust, community-oriented, and comprehensive system of care. The plan funds a community-based, regional crisis triage center, triples available short-term crisis residential beds, increases access to local hospital psychiatric services, and streamlines community-based assessment, case management, and counseling. This plan offers accessible, efficient consumer and recovery-oriented services in the community, rather than the State-run institution. This plan keeps pace with the 60's deinstitutionalization movement and the goals that were set forth there for service of dignity of each individual.

MR. MORADO: Thirty seconds.

MR. EATON: This new model was created with broad cooperation and input from regional providers and guidance from the Illinois Department of Mental Health. This plan has the support of our three local health systems, the Rockford Health Council, the Rockford Chamber

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of Commerce, the Winnebago County Board Chairman, and community mental health providers in Rockford, Belvidere, McHenry, Freeport, Dixon, and DeKalb. They believe, as I do, that it is time to move away from the status quo, away from an ineffective system of care that allows too many people to slip through the cracks.

VICE-CHAIRMAN HAYES: Thank you, Mr. Eaton.

Our next speaker is Michael Butterworth, and he's in opposition.

MR. BUTTERWORTH: Michael Butterworth (spells last name). Currently, I work in the business office at Singer Mental Health Center. I'm also the local AFSCME President, and we've been involved in this struggle to keep Singer open for over a year now. We've heard a lot of talk about the plans. We've heard it today, and we've heard it out in the community. One of the things that we haven't heard them talking about today is the fact -- that the criteria of patients that this plan is addressing. Today I submitted to you a copy of that plan, as well. What it indicates is that this plan addresses those patients which are, by their definition, volunteering, medically stable, funded patients, and those patients are not the patients we currently serve. So, the question goes back to, what's going to happen the patients that we currently serve?

While we acknowledge that the plan set forth is a grand plan, it's an ideal for the way a mental health system should run, but, unfortunately, it still doesn't address the issue of what do we do with the patient that we currently serve? As you see by the arguments submitted by the Mental Health Summit, that capacity for the state is already stretched, and with the closing of Tinley in the beginning of July, those resources are stretched even further.

And now we're talking about sending patients over 45 miles or more to State-operated facilities in Elgin, McFarland, Chicago. So, the question we ask continues. What are we going to do with the patients we currently serve, when we know the community health plan does not address those patients?

Thank you.

VICE-CHAIRMAN HAYES: Thank you. Now, can -- thank you, gentlemen, and if you could -- we'll call up the next set of six.

(Pause)

VICE-CHAIRMAN HAYES: I'd like to call Mary Ann Abate in support; Linda Kobler in opposition; Ann Gantzer in support; Mary A. Birckley in opposition; and Rebecca Cook Kendall in support; and Steven Spencer in

opposition.

(Pause)

VICE-CHAIRMAN HAYES: Now, Mary Ann Abate in support, if you could--

MS. ABATE: Mary Ann Abate (spells name). I am the Chief Operating Officer for Mental Health Services at Rosecrance Health Network. I have managed emergency services for people with serious mental illness in Winnebago and Boone County for over 25 years.

I can tell you without reservation that our current system of response and treatment is not working. For the past two years, we've had an extremely difficult time accessing beds at Singer. It was built to serve 9 counties and is now serving 23, with only a total of 45 available beds. We have been sending clients out of Rockford, out of Winnebago, Boone County for over two years to the Chicago area to access any kind of psychiatric beds. Our clients and others from our region in psychiatric crisis too often languish for hours and even days in our emergency rooms, while we're searching in vain for appropriate placements.

Now we have a better plan developed carefully and in concert with other area providers and with guidance from the Department of Mental Health. It's a great plan,

because it allows us to intercept individuals in psychiatric crisis before they even need the Emergency Room. The behavioral health triage center plan, with the recovery model --

MR. MORADO: Thirty seconds.

MS. ABATE: -- will stabilize individuals and link them with ongoing services. The plan will expand current services, increase sufficiency, and improve the continuum of care in our community for individuals with serious mental illness.

For all the above-stated reasons, I support the closure of Singer. Thank you.

VICE-CHAIRMAN HAYES: Thank you.

Our next speaker will be Linda Kobler, and she's in opposition.

MS. KOBLER: (Spells name). Despite conjecture, theory, and state projections, the reality remains that individuals with severe mental illness will continue to require inpatient hospitalizations in State facilities. Those who were court-ordered, violent and eminent danger in harming themselves or others progressing to being unfit to stand trial will remain inappropriate for community and crisis care.

I am a Registered Nurse at Singer Mental

Health Center. My job is dangerous. I cannot care for the average individual person who could be served in the community at any of these agencies, and the proposal for these individuals will be that they will be transported, actually, to other State-operated facilities. There was a letter to the Board that actually stated that in the rare situation, that an individual who is violent is presented for admission, DHS has assured the program that that individual will be transferred to a State-operated facility. The problem is, that's not a rare opportunity. We admit -- we have 7 to 14 referrals per day in Singer for violent or inappropriate individuals in our hospital and our community of 21 counties. These are the people who are going to suffer if Singer closes.

We have several suggestions where people have been found dead in their apartments in community placement several days after their death, because they were so psychotic they were unaware that it was 105 degrees and they had their windows closed. They got heat exposure. These are the individuals who are going to suffer if Singer closes.

MR. MORADO: Thirty seconds.

MS. KOBLER: It will absolutely be a Titanic if you close our State facility. People have the right to

be treated within at least 40 miles of their home. If you had a toothache, you wouldn't want to travel five hours to have it remedied. I implore you, please keep Singer open.

Thank you.

VICE-CHAIRMAN HAYES: Thank you, Ms. Kobler.

Our next speaker would be Ann Gantzer, and she'll be speaking in support.

MS. GANTZER: (Spells name) and I'm the Vice-President of Aging Services and Nursing at Swedish American Hospital in Rockford. Our Emergency Room is the largest provider for the psychiatric patients in our region. I'm here in support of the rebalancing plan for caring for both the funded and unfunded psychiatric patients, and I'm in support of closing Singer.

As a healthcare provider, Swedish American Hospital understands the importance of providing care to those that are served at State facilities, and I believe that our plan will provide the same or better level of care. Collaborating with the other providers in our region, a new approach has been created to ensure that care across the continuum remains a priority. Access to care in locations other than the emergency room is central to this concept. When appropriate, seeking care from either the emergency room and/or inpatient units will continue to be

an option, but with this new model, alternative care options will exist, and that will prevent those from falling through the cracks.

Reacting to both the current situation and with a proactive look to the future, those of us involved with this new plan believe that we can, and will, provide quality care for the psychiatric population. This plan will allow for a better system of care in our community.

Thank you.

VICE-CHAIRMAN HAYES: Thank you, Ms. Gantzer.

Our next speaker will be Mary A. Birckley, and she is speaking in opposition.

MS. BIRCKLEY: Thank you. My name is Mary A. Birckley (spells name). I'm a Mental Health Technician 2 at Singer Mental Health. On Friday, September 7th, I accompanied a Singer patient, along with his caseworker, to Rosecrance, where he had a meeting for assistance in after-care plans. We arrived at 7:40. There were a number of people already standing outside the door. We were allowed in at eight o'clock. By 8:20, they were already turning people away, saying, "Come back, be here earlier," on a Monday morning, with no place to sit outside for them to wait. There was an older gentleman there with a cane, who was definitely having problems getting around, and they

expected him to stand outside and wait for an hour in any kind of weather. This is a preview of care that will be offered by the community agencies if Singer Health Center closes. "Take a number and wait in line."

With services waning and refusal of services to most, this is reminiscent of the Great Depression, when services were offered to first-come, first served. If this is a picture of the future of mental health treatment with privatization, it is a sad day, and this is a quote from a book by Clayton Cramer, "My Brother Ron". He says, "Deinstitutionalization degrades and shortens the lives of the mentally ill. It was a well-intentioned but a disastrous mistake. The mentally ill walk libraries, lobbies and public parks. It has increased the danger of random criminal acts and devalued the abandoned, homeless individuals who were unaware of their circumstance."

MR. MORADO: Thirty seconds.

MS. BIRCKLEY: "They were beautiful theories but have little to do with the real world."

I ask that the Board to consider the suffering of those who will continue to require inpatient treatment, those without funds, insurance, or jobs, those who have little hope and no dreams of living a normal life. For those individuals, please keep Singer open, or at least a

collaboration between community agencies and Singer.

Thank you so much.

VICE-CHAIRMAN HAYES: Thank you, Ms. Birckley.

The next speaker will be Rebecca Cook Kendall, and she'll be speaking in support.

MS. KENDALL: Rebecca Cook Kendall (spells name). Good morning. I'm Rebecca Cook Kendall and I'm the Executive Director of Rockford Health Council. Our organization is a broad-based collaborative that exists to build and improve community health in our region through education, action, and advocacy. Our Board of Directors is made up of representatives from health systems, government, not-for-profits, education, business, and the medical and the dental society, and has provided leadership and input into the planning and development for the closing of Singer Mental Health. This has presented us an opportunity to look at the critical need in our community and assess how we can provide adequate and appropriate care for individuals in psychiatric crisis.

As has been stated, the plan we have is creating a better system than what is -- for what is already in place. It's a new approach to an old problem. The model includes a regional triage center to provide

services and care for behavioral health patients. We firmly request that you make available opportunities for this regional triage center to be in place. It will -- this facility will strengthen and increase efficiency for behavioral health patients, avoid inappropriate referrals to hospital emergency rooms and jail. This will also --

MR. MORADO: Thirty seconds.

MS. KENDALL: -- give the community system the resources to begin appropriate community treatment for those in need. We have a plan. We're ready to move forward. Rockford Health Council and its board supports collaborative plan to implement a system of care.

Thank you very much.

VICE-CHAIRMAN HAYES: Thank you, Ms. Kendall.

Our next speaker will be Steven Spencer in opposition.

MR. SPENCER: Steven Spencer (spells name). I work as a psychologist at Singer Mental Health Center. I'm here on behalf of Singer and our concern for the future of the individuals with severe mental illness whom Singer serves from our own county and 20 other counties in the catchment area. My concern stems from the series of articles published in the New York Times last year and more recently in the Chicago Tribune that suggest that the main

beneficiaries of privatization of mental health services by states such as New York, Florida, and Illinois, have been the CEO's of non-profit corporations, at the expense of the State and the patients purportedly served. The information in these reports suggests that the confluence of the monetary motivations of so-called non-profit organizations, the severity of our treatment population, and the historic lack of clinical and physical oversight of such organizations have led to questionable, if not gross, mismanagement of funds and of patient's health.

I implore the Board and this State to review the public information that is now becoming available regarding privatization for individuals with psychiatric disorders in the state and those who provide humane services to this population and the community.

Thank you.

VICE-CHAIRMAN HAYES: Thank you, Mr. Spencer.

Now, if we could call the next individuals to the table. Jordan Litvak in support; Robert Izal in opposition; Richard Berg in opposition; Joe Bruscato in opposition; and Michael Gelder in support.

And when you're -- when you -- when I introduce you, if you could spell your name to the -- for the Court Reporter. So why don't we start out with Jordan

Litvak in support.

MR. LITVAK: (Spells name). This is a letter from Dr. David Deopere, President of the Robert Young Center, addressed to Mr. Galassie, Chair of the Health Facilities Services Review Board. He asked me to read this into the record.

Dear Mr. Galassie: Given the vast budget deficit in the State of Illinois, it is obvious that significant adjustments must occur in all spheres of state government. Among the planned expense reductions in Illinois is the closure of certain state-operate facilities, such as Singer Mental Health Center. Theoretically, one must assess if existing patients currently being treated at Singer can acquire supportive behavioral services in their home communities and reside in a safe and supportive environment.

While closure is not the most ideal scenario, it is our belief the Department of Mental Health has engaged in a sincere rebalancing effort whereby consideration has been given to reinvesting in community services that encompass local treatment and recovery options for the severe and persistently mentally ill who otherwise might be referred to Singer Mental Health Center. A plan we submitted to DMH was approved and it will allow

us to enhance behavioral crisis intervention services at Trinity Medical Center well as surrounding hospitals in our region. The Robert Young Center for Community Mental Health, Trinity Medical Center has experienced the closure of East Moline Mental Health, Galesburg Research Hospital, and Zeller Zone Center. In each instance, supportive services were funded by the Department of Mental Health to develop appropriate community services. It has worked.

However, it is also important to understand that high acuity behavioral patients present --

MR. MORADO: Thirty seconds.

MR. LITVAK -- a substantial safety burden to community hospitals that contain psychiatric units. A community hospital is simply not staffed to restrain combative, violent patients. We've been assured that in the infrequent instance when we are faced with a particular combative and violent patient, that an alternative State-operated facility will be made available. We have a long history of positive deflection of patients from State hospitals. So, given the approved plan for additional community crisis services, coupled with the assurance that DMH will coordinate safe patient placement, we support the closure of Singer Mental Health Center.

Thank you.

THE COURT: Thank you, Mr. Litvak.

Our next speaker will be Robert Izal, in opposition.

MR. IZAL: My name is Robert Izal (spells name). I'm a psychologist and Quality Manager and Forensic Coordinator and qualified mental retardation professionalist here in the Law Center, so I know a lot about what's really happening at Singer. I'd like to speak to statements made in the Department of Mental Health's correspondence, dated September 3rd, in which they (unintelligible) finding that the, quote, proposed discontinuation will have a negative impact on chronic mental illness services provided in the Service Area.

The Department asserts that, quote, without the Board's calculation of either bed need or excess, the impact of this continuation cannot be assessed or verified against the standard. In other words, you can't assess the truth. We can calculate the impact by looking at Singer's admission. Singer Mental Health Center has (unintelligible) for 76 beds. However, for several months now, the Department has reduced our census from 76 beds to between 40 and 50 beds. There was no admission waiting list when we were at 76 beds. Since the census was reduced to 45, on July 27th the average number of patients waiting

in the emergency rooms has been 7.8 patients. The largest number of patients waiting on a given day was 13; the lowest number of patients during that period was 4, never zero. Average length of wait during that period, not counting one patient waiting for 40 days on a hospital psychiatric unit who would have artificially inflated the average -- taking him out of the equation, the average wait for admission during that period for the other patients was five days. That's an average of 7.8 patients waiting an average of 5 days each. It's a disability discrimination suit waiting to happen.

The Department states in its September 3rd response that Singer's utilization rate is 3.7 percent lower than the Board's target of 90 percent.

MR. MORADO: Thirty seconds.

MR. IZAL: That table shows the Department's rates state-wide is 2 percent lower than Singer's. Why? Because four other State hospitals have lower utilization rates than Singer has, hardly a case for singling out Singer, and so far this fiscal year, with the Department's mandate to lower census and our admission waiting list, our utilization rate is 96 percent.

The State claims community providers will treat those now referred to Singer Mental Health Center,

but what they fail to mention is that those very providers are the ones that are referring patients to Singer's waiting list and are the providers who turn down those patients that we have that we would like to see placed in the community. The State claims that it wants to close Singer because of their rebalancing philosophy of rebalancing services to the community -- a sudden interest in the Olmstead Decision of 1999.

No miracle cure for the chronically mentally ill has come along. We all know it's about the money and that a philosophy has followed the money. God save those who didn't ask to be so mentally disabled that they could not succeed in the community, as we pretend they will rebalance their disabilities now.

Thank you.

VICE-CHAIRMAN HAYES: Thank you, Mr. Izal.

Our next speaker will be Richard Berg, and he'll be speaking in opposition.

MR. BERG: Richard Berg (spells name). I'm the staff representative for AFSCME Council 31, and our Union strongly objects to the closure of Singer for the following reasons:

DHS cannot verify its reasons for the discontinuation under the Act. DHS says the facility is

not economically feasible due to reduction in the agency's Fiscal 2013 appropriations. The fact is, 2013 and 2012 appropriations were virtually the same, and Tinley Park has closed since then. In 2012, it was $204.8 million and in 2013, it was $202.7 million.

Secondly, DHS cannot document, as required by Rule, that the closure will not have an adverse impact on access to care. The Staff report of the DHS application to close Singer finds that it has not been done and correctly finds the application non-compliant on that basis. In the DHS reply to the Board, the Board Staff report, the Department notes that the purchase of as many as 681 admissions at five hospitals. Those admissions are for only six days, much shorter than the average length of stay at Singer. If you break it down, 681 admissions multiplied by 6 days is a little over 4,000 bed days. Dividing by the days in the year, that's less than 12 beds, compared to the 56 beds and last year's 76 beds at Singer. Furthermore, one of the 5 hospitals from which those beds are to be purchased is not even in the Singer catchment area. DHS has refused to say how the 12 beds --

MR. MORADO: Thirty seconds.

MR. BERG: -- are distributed among the five hospitals. It is important to note that these are not 12

additional beds. The number of available beds remains the same, and the testimony of hospitals, community mental health centers, and consumers has made it clear that there are not sufficient beds in the region, even with Singer open, to avoid the long waits in the ER's -- in some of the cases, several days.

Singer is well utilized. Singer is the only safety net hospital serving all mentally ill, including those who are uninsured, involuntarily admitted for treatment, and a danger to themselves and others in 21 counties in northwest and north central Illinois.

MR. MORADO: Please conclude your comments.

MR. BERG: It would be a tragedy if we close Singer Mental Health Center. Thank you.

VICE-CHAIRMAN HAYES: Thank you, Mr. Berg.

Our next public comment will be Joe Bruscato, and he's in opposition.

MR. BRUSCATO: Joe Bruscato (spells name). Good morning, Mr. Chairman and Members of the Board and the Staff. My name is Joe Bruscato. I'm the Winnebago County State's Attorney.

To date, I have written to all of the State's Attorneys who are affected by the potential closing of Singer. I have yet to receive any information or response

from any State's Attorney who supports the closing of Singer Mental Health Center. In fact, I have received the opposite. Those State's Attorneys who have taken the time to respond to me directly oppose the closing of the Singer Mental Health Center.

We as State's Attorneys know the importance of mental health courts and the treatment that is necessary to provide help to those with mental health concerns so that they themselves can avoid continuing in the criminal justice system and avoid pitfalls of recidivism. I must concur with State Representative John Cabello. I am not yet, at this point in time, satisfied that I understand and know the extent of the planned program that has been proposed.

Those individuals from the community, especially in the Winnebago area that have spoken to you today, are well-respected professionals that I have worked with, but I must say at this point in time that the I have an inability to completely understand the system and plan that is proposed and how it addresses very realistic concerns of facility distance, funding, reinvestment in our community, as well as how it affects my fellow State's Attorneys, because, as we know, crime does not follow orders. It is important that we take the time to look at

the plans and programs in any change.

MR. MORADO: Thirty seconds.

MR. BRUSCATO: I think at this stage, any moves to close the Singer facility would be at the very least premature. I believe that the impact on Winnebago and the other counties would be significant, when you take into account the severe and often challenged individuals from a mental health standpoint and that their success -- or at least the chance of success -- in the criminal justice system hinges on being able to be cared for.

I strongly urge that at this time, you keep the Singer Mental Health Center open until the community of Winnebago County and the other communities, especially that of the criminal justice system -- and as State's Attorney, I can state that I, as yet, do not understand what the alternative plan would be in funding. Without that, I think we need to take a pause, at the very least.

I thank you for your time and the ability to address all of you.

VICE-CHAIRMAN HAYES: Thank you, Mr. Bruscato.

Our next speaker is Michael Gelder and he's in support.

MR. GELDER: Thank you very much,

Mr. Chairman, Members of the Board. My name is Michael Gelder (spells name). I'm Governor Quinn's Senior Health Policy Advisory, and I'm here in support of our application to close Singer Mental Health Center.

On January 19th of this year, Governor Quinn announced his intention to transform the way Illinois provides care to the people with mental illness and developmental disability. This transformation involves rebalancing spending from care in large institutions to smaller, community-based settings. This transformation is consistent with our obligations under the Americans with Disabilities Act and the subsequent Supreme Court Olmstead Decision, which calls for State programs to offer care to people in the least restrictive settings.

The Governor's commitment to home and community-based services has taken several approaches. We have settled three class action lawsuits based on violations of the ADA and the Olmstead Decision. We have secured significant additional Federal matching funds under Medicaid by helping to move hundreds of older adults and people with disabilities, living in nursing homes, who wish to and can safely move into the community, and we are closing State institutions and reallocating funds to provide care in smaller community settings.

We are here today to discuss the urgent need to close Singer Mental Health Center. The State psychiatric hospital has served people in the west part of the state for decades, but the state of the art for helping to care for people with serious mental health problems is no longer a State psychiatric hospital. Experts have learned that enhanced, community mental health services, coupled with crisis intervention and funding of private inpatient hospital services, when needed, is the most cost-effective way to meet the needs of those with serious mental illness. Cost effectiveness is a dire concern to Governor Quinn and the taxpayers throughout the State. Rebalancing --

MR. MORADO: Thirty seconds.

MR. GELDER: -- spending on home and community-based services coincides with the need to balance the State's budget. Indeed, the Fiscal Year 2013 appropriation calls for facility closings with the reallocation of significant sums to enhance community services.

We have no intention to let anyone fall through the cracks. Indeed, the State hospital today is the net that catches those who fall through the cracks. Our intent is to additionally fund community mental health

services, reduce the need for psychiatric admissions, and with the new crisis intervention system, divert even more people from expensive and frequently unproductive hospital stays. On behalf of Governor Quinn, I urge you to support this fiscally prudent and policy-driven application of State policy.

Thank you very much.

VICE-CHAIRMAN HAYES: Thank you, Mr. Gelder.

Now, I'd like to -- the Court Reporter needs some time to be able to change her tape, so I'd like to take a 10-minute break, and so we'll be back here at 1:35 -- 11:35, and I'd like to make sure that everyone comes back at that time so we can get to -- continue on.

(Recess)

VICE-CHAIRMAN HAYES: The meeting will come to order.

(Pause)

VICE-CHAIRMAN HAYES: I'd like to continue with Applications Subsequent to Initial Review. We're on Project 12-060, Singer Mental Healthcare Center, Rockford, and if I could have the applicants come to the table, and if they could state their name and be sworn in, and we'll go from there.

MS. FERGUSON: Good morning. My name is

Dr. Debra Ferguson. I'm the Senior Deputy and Chief of Clinical Operations for the Division of Mental Health.

MR. PELLETIER: My name is Michael Pelletier (spells name). I'm Special Assistant to the Director for the Division of Mental Health.

MR. GELDER: And I don't know whether it's appropriate -- Michael Gelder. I'm Governor Quinn's Senior Health Policy Advisor, and since we are part of this, I thought it might be helpful to be here to answer questions.

VICE-CHAIRMAN HAYES: Yes.

MS. OLSON: Yes.

VICE-CHAIRMAN HAYES: Mike, Staff report?

MR. CONSTANTINO: Thank you, Mr. Chairman. The applicants are proposing the discontinuation of a 76-bed chronic mental illness facility in Rockford, Illinois. There is no cost to the project. The anticipated project completion date is October 1st, 2012.

I would like to comment on one thing. Attached to the back of your report is -- I had inadvertently attached Methodist Hospital of Chicago to this report. I apologize for that.

Thank you, Mr. Chairman.

VICE-CHAIRMAN HAYES: Thank you, Mike.

Now, if we could have the applicant give a

presentation.

(Oath given)

MS. FERGUSON: Good morning. Thank you for this opportunity to address the Board on behalf of Dr. Lorrie Jones, Director of the Division of Mental Health.

The H D Singer Mental Health Center is regulated by the Board as a long-term care facility, providing chronic mental illness category of service. Its closure is proposed as part of the Governor's plan to rebalance the manner in which care is provided to individuals with mental illnesses and developmental disabilities away from large, institutional settings towards smaller, community-based treatment settings.

Since the time we submitted our application in June, considerable work has been done, further refining, developing, and finalizing our plans for services for those individuals previously served by Singer. Our planning process has been a collaborative one, relying on the input, direction, and expertise of a large group of clinical and regional experts. Numerous meetings were conducted, including a clinical focus group, aimed at identifying and quantifying the clinical and service needs of the Singer population. Through this partnership, a plan for a new

community-based crisis care system was developed, reflecting the needs and priorities identified by these regional experts. A request for information was developed for providers wishing to offer services under this new northwest crisis care system. The proposals were reviewed by a group of State community services experts, and proposals deemed best able to meet the needs of the region were selected.

The components of the new crisis care system are as follows:

$2.6 million in community hospital, inpatient, psychiatric services for replacement inpatient bed days;

$2.25 million in support to emergency departments and a regional crisis triage center for on-site crisis assessment and disposition;

658,000 in intensive, post-discharge treatment services;

461,000 in crisis residential services;

$350,000 in transportation services;

And some additional services, for an annual total of 7.3 million in community reinvestment.

The development of the Northwest Crisis Care System has been a collaborative, data-driven process that is bolstered by our successful experience with the Tinley

Park closure, and focused on ensuring access and services are maintained for individuals previously served by Singer Mental Health Center. By facilitating consumers' access to care in the community, and at the level of care most appropriate for their clinical needs, outcomes are improved, while promoting greater integration with families, peer supports, other health providers, and Human Services supports. Individuals previously served by Singer will have an array of services available to assist them in achieving recovery and participating fully in their communities.

Mr. Gelder, Mr. Pelletier, and I would be happy to answer any questions you may have. Thank you.

VICE-CHAIRMAN HAYES: Thank you.

Can I open up the -- for Board questions?

MS. OLSON: I actually have several questions, so I'm just going to start down my list.

First of all, maybe the representative from the Governor's office can answer this question. Much has been said about the fact that there is money allocated in the budget to keep Singer open this year. Is that money that we've been talking about part of the 7.3 million that's going to be used for community-based services, or what's the discrepancy in that statement?

MR. GELDER: The money that is appropriated for -- within the Department of Human Services budget is the money that would be used in that -- as Dr. Ferguson outlined, the 7.3 million will be used to enhance community services throughout the northwest area and Illinois.

MS. OLSON: Thank you. My next question is, I don't think that anybody has issue with the residents that can be placed in a community setting, and I'm very familiar with both Ben Gordon and Rosecrance, and they are very reputable organizations. But it's these forensic patients, the patients that Representative Cabello and State's Attorney Bruscato refer to that seem to be a concern, and I'm guessing that this plan has been enhanced or changed since the June hearing that I was at, because at the June hearing, my understanding is that the Winnebago County -- I know the Winnebago County Board representative spoke in opposition, and I'm now told they're now in support of the plan. So has the plan changed since June?

MS. FERGUSON: Since June, we engaged, as I described, in a very elaborate and extensive planning process with region providers; and so, since the time we submitted our application, we have further refined and finalized our plan and made decisions about community reinvestment. So those decisions had not been made at the

time we submitted our application, and so now we have a finalized plan in place.

MS. OLSON: And that's the letter that was sent to Chairman Galassie on September 3rd, outlining your plan?

MS. FERGUSON: That's correct.

MS. OLSON: So, is this plan public information? Because I'm concerned that Representative Cabello and Joe Bruscato, the State's Attorney, don't have access to -- they said they don't have the plan. I don't understand that.

MS. FERGUSON: We will certainly make it available. We began our roll-out of the plan just this week, to providers and stakeholders in the area. Out of respect for the Board, we wanted to present it to the Board and describe it to you. We will certainly make it available to anybody who would like to see it, and we'll also publish it on our DHS web site.

MS. OLSON: Thank you. And then so these forensic patients, the people that clearly are not going to be able to live in the community, the piece of the plan that addresses them is, they would be transferred to another State-operated facility. Is there a capacity at these other State-operated facilities to handle those

additional patients?

MS. FERGUSON: Yes. We have engaged in a process of extensive forensic UR to create capacity on our forensic units for individuals who continue to need inpatient level of care and who are forensically involved. So, those individuals will be moved either to Elgin Mental Health Center or McFarland Mental Health Center.

MS. OLSON: Which is in Chicago?

MS. FERGUSON: McFarland is in Springfield and Elgin is in Elgin.

MS. OLSON: And I guess finally -- well, maybe not finally, but one of my biggest concerns --

MR. GELDER: Let me just add, just to enhance the answer to the question, there's been no -- I don't know that anybody has been intending to imply this, but this has not been in done in secret or in any way that would exclude anybody who has been interested in this. Dr. Ferguson can describe in more detail. There were five meetings that occurred in the community with -- people weren't kept away from that -- where the plan was developed and worked out with various interested parties. So, we've been trying to do it in a very open, transparent way, and it will be available to the public shortly. We didn't want to do it in advance of this meeting today.

MS. OLSON: Thank you. My biggest concern at the hearing in June -- plus here today -- the Swedish American emergency physician spoke to the fact that they at times had people waiting in the emergency room on a gurney or in a hospital emergency room for five to 12 days to get any kind of placement. So, I'm assuming that the plan rigorously addresses those kinds of issues, because that would be a huge concern, and I'm very encouraged to see that Swedish American are personally in support of the plan at this point so that has been addressed in the new plan.

MS. FERGUSON: Yes. One of the -- I think the primary way that -- that's really been addressed in two ways: Number one, in the purchase of nearly 4,100 replacement bed days in the community, but also in the development of a crisis care system that offers alternatives to inpatient treatment for individuals who don't need that level of care. We really believe that by directing people quickly and efficiently and appropriately to the least restrictive level of care located in their communities, people do recover better and are better able to resume productive lives.

MS. OLSON: And I would say that that would be very difficult for anybody to argue with, and I can tell you, part of my background has been in the world of people

with developmental disabilities, and Illinois has always been criticized as a state that's way behind every other state in deinstitutionalizing these folks, but I think what our Board needs to be assured of is that it's going to be done in a responsible manner, certainly with the patient at the center of any plan that's devised.

MS. FERGUSON: That certainly is our priority, and although the data from the Tinley closure is preliminary, what we have so far certainly suggests that ED wait times are reduced, that people are moved to point of service within less than an hour, and that people have access to care and are able to get to the point of service quickly and efficiently, moving through the Regional Southwest Crisis Center. We have that same goal for the Northwest Crisis Center.

VICE-CHAIRMAN HAYES: Member Sewell?

MR. SEWELL: I heard what Michael Gelder said about the contemporary approach to dealing with these patients being away from institutions as much as possible and being community based. My focus in this whole application is really on this plan, and I saw in the application the meeting summaries for the meetings you all referred to. I think there were four or five, maybe six, and a pretty impressive array of people who -- the sign-in

sheets were in the application, and we saw who was there. The focus for me is on two categories of patients, though. I think Ms. Olson already talked about forensic patients, and I guess what I would want to know is, have you analyzed the post-Singer discontinuation world from the perspective of the population of forensic patients and indigent patients, and can you -- if you have, could you say that the system will be -- in terms of capacity, will be better able, or at least as able, or less able to deal with the phenomena of forensic patients and indigent patients? These seem to be the two most difficult categories that we're talking about in this discontinuation.

MS. FERGUSON: Yes. So, for forensically-involved individuals, as I said, we're engaged in a vigorous process of UR to maximize our capacity in our State-operated facilities that provide forensic services. So, yes, I believe that we will be able to continue to meet that capacity.

MR. SEWELL: At pretty much the same level, not greater or less?

MS. FERGUSON: Correct.

MR. SEWELL: Okay.

MS. FERGUSON: With respect to the indigent population, I actually believe that the plan that we are

proposing improves care to them. It certainly improves access to care, and it certainly improves the array of care that's available to them. We really believe that our obligation, as we rebalance and transform, is also to improve the system of care, and I think we've done that with the development of this Northwest Crisis Care System.

MR. SEWELL: And final question: Is this system that you envision that's a product of this plan, will it be in place in time to respond to Singer closing? Is this something that's being developed over time and maybe with some State resources -- I think the money was mentioned a while ago. I mean, what's going to happen, you know, a month after Singer closes? Will that system be ready?

MS. FERGUSON: Yes, sir. As a matter of fact, our plan is to have the Northwest Crisis Care System stand up, be fully operational on October 1st, when we plan to discontinue admissions to Singer, with the ultimate plan to close Singer on October 31st. So, the Northwest Crisis Care System will be fully operational on October 1st when admissions are discontinued.

VICE-CHAIRMAN HAYES: Dr. Burden?

MR. BURDEN: Thank you, Mr. Chairman.

As a physician, I'm listening to, obviously,

opposition to the closure, as well as listening to the attempts to put the rebalancing plan, called the Southwest Community Plan -- is that what the term was?

MS. FERGUSON: The Northwest Crisis Care System.

MR. BURDEN: I'm in the wrong part of the state. That shows my age, Dear. I forgive myself for not paying better attention.

I greatly appreciate comments from my two predecessors here on the Board. As a surgeon-oriented and not really oriented to healthcare, I have some personal reservations about what I've heard. I strongly support, because of my own family -- I have law enforcement people and also people in the mental health, a son who -- a psychologist who runs a large university-based mental healthcare service, and I listen to the pros and cons between police enforcement members of my family, and I listen carefully to that. So, I personally have some reservations about going forward at this moment with a positive approach. I would be more comfortable if I listened and heard more about rebalancing, quote, unquote. I've dealt extensively with rebalancing in the medical community for 40 years. I heard the plan. I heard the closure in a very short period of time. I'm comfortable

hearing what other Board members feel, but I would wonder -- and this is part of my concern. This is all about money, in my humble opinion. Same thing is going on in Chicago now with the Teachers' Union. I respect union members who will support -- we have union people on the Board, but I'm always curious when I hear a large union being for this change, which means to me that their monies are going to be in place. I listened to physicians who care and policemen who care for them. They're on the streets, getting these people and caring for them and have great concerns about what's going on here.

The rebalancing advisory committee probably had people who I would feel more comfortable with their opinions regarding the change, personally, but I'm listening to physicians and psychologists who are anxious about what's coming. I understand the money. I understand the Governor is concerned about where we are as a state. I wonder if the union that represents the healthcare workers is willing to take a little cut in pay or look at it as an opportunity to help solve our problems in this state, which really come to money. That's what I'm listening to here. That's me personally. I'm not prepared to comment about the extensive feelings that other Board members have, having attended other meetings, but I'm looking at some

data here. I'd like to hear more about it.

I'm very sympathetic to what I hear from the physicians who treat these folks on a daily basis and the cops on the street. That's my background, so that's where I would be at this moment. I'm not overwhelmed with what I hear happening in such a short span of time. I am concurring that the problems of money has to be addressed, but I'd like to hear personally a more balanced approach and maybe have an opportunity to really see this plan that is being imposed, and I didn't hear that the people I spoke about have had adequate assurance that this plan is acceptable to them. That's where I'm coming from on this topic.

VICE-CHAIRMAN HAYES: I recognize Member Senator Demuzio.

MS. DEMUZIO: Just to basically follow up what Dr. Burden said, a question in regard to the plan. Is something addressed in the plan, or do you have plans, in regard to the employees that are presently employed at Singer? Where do they go? How do you address that?

MS. FERGUSON: The employees at Singer Mental Health Center currently are offered opportunities in other State-operated facilities, other State agencies, and other vacancies across the state, consistent with their rights

under the Collective Bargaining Agreement. So, that process has been initiated and I believe has been completed.

MS. DEMUZIO: And do you have any idea how many will be -- how many will have to relocate, or will any of them get to stay within their same areas?

MS. FERGUSON: I apologize, Senator. I don't have exact numbers on how many people are relocating. I know that several staff members are moving, to maintain their State employment, yes.

MS. DEMUZIO: Thank you.

VICE-CHAIRMAN HAYES: I recognize Member Sewell.

MR. SEWELL: Would the Department agree to report to our Staff here numbers related to the capacity of the system to treat forensic patients and indigent patients after October 31st, for maybe the first year?

MS. FERGUSON: Certainly.

VICE-CHAIRMAN HAYES: I'd like to recognize Mr. Eaker.

MR. EAKER: Yes. I have many concerns from many different perspectives. I'm here as a voice of consumers and patients, and I am greatly grieved on the pattern that has continued on down the line of governmental

agencies wanting to balance the budget on the backs of the elderly, the poor, the ill, and now the mentally ill. I think we need to look at other ways to balance the budget, and the adverse results of access to care in this community and any other community where we seek to do that is very questionable. I could say much more, but at this point, I'm just dumbfounded that we continue this process of closing -- actually closing facilities, before coming to this Board, by choking it off, reducing beds, laying off staff and then coming to us to rubber stamp the actions.

(Applause)

MR. GELDER: We appreciate that, and that is not a -- that is not the first time we've heard concerns expressed about the way in which State Government is trying to balance its financial footing. I would point out that the people you enumerated, the sick, the poor, are the ones on whom the State spends money. So, it is unlikely that any effort to spend less, that the people for -- who receive the vast, vast majority of funding from the State wouldn't be impacted to some extent. That's just the reality the State has to contend with. We spend almost all of our money on a few programs targeted to a few groups of people and so, if we're going to spend less in any way, we're going to have to spend less on those programs.

Having said that -- which is, I think, undeniable reality -- we've gone through this in the Medicaid program and other State-operated facilities. We're doing everything we can to secure additional Federal funding to help diminish the amount of cuts that we have to make, and we are trying very hard in this particular case to assure that the services that people need, before they get to a crisis stage and need a hospital bed, which is all they would have available now, will be ameliorated. Care will actually improve for this population, if we can shift the spending from operating a State hospital to applying those funds in ways that are much more, much more beneficial for the people with mental illnesses, the family members with mental illness. They should have more than they have today, and they're not going to get more than they have today, because we don't have any money to spend on keeping the old services and adding new services, so they're not going to get those community-based services unless we can reallocate that funding.

It does look like, as you described -- I don't see any way humanly possible to stop spending money on the very people that we're spending it on and still spend the same amount of money. It just -- it's a bad arithmetic problem.

MS. FERGUSON: And if I could just add on to Mr. Gelder's comments -- I'm a clinical and forensic psychologist with some 28 years of experience, and I can tell you that if this state were flush and money were no consideration, I'd still be here advocating for the Northwest Crisis Care System, because I do believe that it represents an improvement in the access and care provided to consumers in the region. It does allow for them to be treated closer to their communities and at a level of care that is more appropriate to their clinical needs, and it does ease their reintegration into the community and allow them to have the support of their friends, family and community as they recover. So, I really do see this as an improvement in the quality of care.

MR. EAKER: Therein lies the dilemma that we have. I've appreciated all of the people who have spoke on both sides of the issue. There seems to be a real dichotomy of facts and issues. But, personally, I would like to see this application deferred until more can be fleshed out. I know time seems to be of essence, as far as the State saving money, but really, fleshing out of the forensic care, the other issues that law enforcement have, are all issues that really do not add up. All of you have made great presentations, but I am not sure that this Board

is ready to really consider all of those facts.

MR. GELDER: This is our opportunity to answer your questions about the effort that's been under way, as Dr. Ferguson said, for the last three months, June, July, and August. It's your deadlines that caused us to submit our plan in June, before those contracts and all those meetings and negotiations with local providers and advocacy groups occurred. That's -- so we are here today, ready to answer the concerns. If you want to know about forensic beds, we can provide the answers for forensic beds. There's no mystery and there's no shortage of information. That's what we're -- that's why you're having this hearing, I presume, and that's why we're here to answer your questions. Are there specific questions that you have?

VICE-CHAIRMAN HAYES: Yes. I recognize Justice Greiman.

MR. GREIMAN: Let me comment. My guess is I won't get applause. But as to your comment that it's important that people are serviced quickly near their residence, instead, we're taking and closing down Rockford and telling Rockford they can go to Elgin or to Springfield if they want service? That's not exactly how I see getting them home, but what I want to ask -- forget that part. What I want to ask is -- this, along with two other places,

is a fundraising expense cutting. That's okay. I get that. How much do we save actually by closing Singer? How much less is the budget? I guess what I want to know is, it really worthwhile? Is it a significant amount of money?

MS. FERGUSON: The hospital operations in this year's appropriation was about $202 million. That included the operations for Singer Mental Health Center. However, this year's appropriation also granted us the authority to use money in that appropriations line for transitioning individuals into alternative treatment settings. So, once Tinley Park closed, we used about $10 million from that hospital appropriations line to support the community reinvestment in Region 1 south. So, what that means is, what was left was about $193 million, which is insufficient to operate the remaining eight hospitals. I'm not sure what the actual savings is for Singer, after the community reinvestment, annual amount of 7.3, but we could get you that number.

MR. GREIMAN: I am interested, because, look, we're going to be servicing these people at other places, and it's going to cost money in other places. So, is it really -- are we closing it for real money or just --

MR. ELDER: One of the challenges in answering that question, Justice Greiman, is the way in which the

General Assembly budgets, allocates, appropriates for mental health services. So, there's a lump sum appropriation for all of the State facilities, and so finding out how much would be saved in any one facility closing is -- involves a lot of assumptions and effort.

MR. GREIMAN: So, you don't have figures that tell you how much it costs to get -- for Ed and Joe to be serviced? You don't --

MR. GELDER: Yeah, we would have numbers for Ed and Joe. I think there's two numbers. I'll let Mike Pelletier and Debra Ferguson give you some of those details, but I think the important number for some of us, like myself, who are advocates of community-based services -- I hear some of you saying you agree -- is the 7.3 million that's additional funding for community-based mental health services, including those crisis services. So, that is 7.3 million that we wouldn't have available in any other fashion from the appropriations that have been made, if we don't have that money available from the Singer closing. We have to do one or the other, and our goal -- the Governor's goal is to do it through community-based services rather than operating obsolete institutions.

But can you answer more about the -- how the costs are allocated for the people in the community for the

services.

MR. PELLETIER: Well, my comment goes back to Justice Greiman's issue about moving persons into other State-operated hospitals and Dr. Burden's issue in terms of the perception. First of all, Justice, the plan that we outline for $2.6 million inpatient services, inpatient bed days brings those bed days into the communities where those consumers reside. We are contracting with hospitals in Moline, in Ottawa, in Aurora, two hospitals in Rockford, significant hospitals. Swedish American is a significant hospital in terms of volumes that will -- and, as you have heard, have given us unqualified support in terms of our plan. So, the first locus of movement of persons that need inpatient care really goes back to the community of residents. The beds that we spoke to you about that are available at the McFarland Mental Health Center and at the Elgin Mental Health Center are for those persons who ultimately need different levels of care, that cannot be handled in these five hospitals where we're purchasing $2.6 million of care.

The providers, Dr. Burden, also represent physicians, psychiatrists, social workers, who are on the ground every day seeing consumers in crisis. These persons are the ones that helped us fashion the plan for this

program. These agencies and these persons gave us their best advice; specifically, how they can continue to support emergency departments providing face-to-face, active, 24-hour-a-day intervention at those emergency rooms, providing that care, getting care that is available for pre-interventional services. Many of the -- several of the agencies that have responded to us and that we are giving crisis intervention monies to are mobilizing their programs on a 24-hour basis, where they go out into the communities on a 24-hour, 365-day, 7-day basis with licensed professionals that will go to schools, that will go to jails, that will go to homes and do those assessments in those settings, in addition to going to the emergency rooms where they are currently attending.

The Rosecrance Center is a unique opportunity for us. They are the largest single agency in Rockford. With Swedish American -- with their partnership with Swedish American in terms of providing medical support, they are the single largest provider, and they are basically saying to us -- and we affirm and we heard throughout the five meetings that are outlined in our application -- they and five other agencies that are represented, the 2 West area, which is the northern sector of the catchment area that responds, that sends patients to

Singer, they basically said to us, "Give us a crisis triage center. Give us a place where we can divert people from the emergency rooms." Mr. Eaton stated that significantly, that with this new program, they are rejecting and anticipating, and in many cases guaranteeing, their reputation to say, "With this program, we're going to divert 30, 40 percent of the people that are currently going to Swedish American Hospital."

Within the program that we funded, the crisis triage program, those persons are not going to go into that setting. That setting is going to have beds available. That setting is going to have a setting that is not a medical emergency room setting. It is a setting that is set up with what we call "living room focused", where consumers are able to stabilize with other persons that we call "persons in recovery", with other professional staff members who themselves have significant history of severe mental illness and have recovered. This crisis triage center is going to divert admissions to the emergency room. The emergency room is not the correct place for a large number of persons. This program, the programs that we funded in 3 North and other agencies, give us the opportunity -- give these agencies the opportunity to do what they asked of us to do when we were having these

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meetings. They asked us, do what we think is best. We're on the ground with these consumers every day. We know -- we gave them data that was from Singer. We asked them to look at their own data. It's outlined in the application, in the minutes that Member Sewell referenced. It's outlined in that, that many of those agencies came back to us at those meetings and said, "If we have a crisis triage center, if we have crisis residential beds available, if we have active monies that are available to us to use for consumers when they're discharged from an inpatient setting when they have to be in an inpatient setting, if we have these monies in addition to the monies that we are asking of the State at that time for enhanced crisis services, these 24-hour operations, these crisis triage centers," they were asserting to us that they felt that up to 50 percent of the persons that went to Singer could benefit from these other services that we're now buying and would not have to be hospitalized at Singer.

So, on the ground, physicians, psychiatrists, social workers, licensed psychologists are telling us that this is the plan that will work. This is the plan that they are asking for. This is the plan that is community specific to each one of the counties and the agencies, and the dichotomy that you're hearing today is basically saying

this is a plan that we know will work. Dr. Deopere, in his letter to the Board, basically said we've gone through this two times with Zeller, and I can't remember the other -- Galesburg, I think he said. We have gone through this two times before, and when the State made this commitment for outpatient services, for inpatient replacement bed services, it worked in our communities, and we listened to our community, we listened to our agencies, and we provided them with what they wanted from us, to make sure that the closure of Singer and the handling of these consumers is going to be effective, clinically appropriate, clinically appropriate to the needs that these persons have when they present in crisis, and with the opportunities that we're buying, with the opportunities that these agencies have asked for, the closure of Singer will ensure that consumers have better access to the right amount of care at the right time, provided by the right community providers.

VICE-CHAIRMAN HAYES: Justice Greiman?

MR. PENN: I had a question. Most of my questions have been asked, but one of the comments during public comments was that this facility has been fully funded for fiscal year 2 -- through 2013, and my concern is -- and what's been asked -- why is this being fast-tracked with the plans, that still seem to be a living

document, still being developed? My concern is when State Representative Cabello says he's not fully aware, State's Attorneys, groups of State's Attorneys, their concern about spike in crime, what kind of a cost would they have for police officers who protect their communities, prosecutors, public defenders, that might be shifted to them, and they're not even in the loop in this plan, nor seems to be employees of Singer, and then you tell us today, "We're holding back just for you." I would think the process to get where you want to go, you would want State Representatives, Attorney Generals and anybody from the court system to step up and say, "This is the best thing for our community." I'm hearing just the opposite today, and I think that plan should probably have been shared with them and they can come to this table in support, which you really want us to vote on.

MS. FERGUSON: Well, as Mr. Gelder said, we've really tried to offer a transparent planning process, and if people didn't have access to the plan, that's -- we apologize for that. We will make it available to them now. We will meet with whatever groups of individuals or individuals privately to reassure them about the scope and the breadth of the plan.

With respect to your question about the

budget, it is, as I explained earlier, that given this year's appropriations, once Tinley closed and monies were used in the reinvestment to support those community services, our hospital operations line no longer has sufficient funds to operate Singer Mental Health Center. So that's one of the factors leading to the urgency of this situation. We certainly believe that by offering services that are front-loaded, intercepting people early in their crisis, before they get to the emergency room, before they come in contact with law enforcement, before they need hospital level of care, that this represents an improvement in services offered to people in the region, and I think the plan describes that.

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

MR. BURDEN: This is a very complicated issue. I think I heard something in there that said Tinley Park closure has really occasioned a necessity that really is over and above what I was led to believe from our earlier conversation to close it. You're running out of dough. I don't want to demean Mr. Mike Pelletier's eloquent defense to this closure. I respect and trust him, and he's been an advisor to this Board, and I appreciate that. However, I just heard something that made me slow down a little bit.

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The closure of Tinley Park -- do I understand what I heard -- has led to a situation where you have only X number of funds to continue running Singer for a shorter period of time than we were led to believe? Is that correct?

MS. FERGUSON: The total hospital operations line for FY '13 was 202 million. Once we -- and that's a lump sum. That's all hospitals together. Once we closed -- and that appropriation authority allowed us to use some of that money in support of the community reinvestment associated with the Tinley closure, and we used some $10 million to do that, from that hospital appropriations line. So, once Tinley closed, you're correct, we no longer had sufficient money in that appropriations line to continue to fund the remaining eight hospitals.

MS. OLSON: Would you explain why Tinley closed?

MS. FERGUSON: Well, Tinley had been decertified several years before, but realistically, Tinley closed as part of the same rebalancing and community reinvestment plan and policy that we're describing to you today.

MR. GELDER: Let me add just quickly. The

comment about us moving quickly on this -- we announced to the Commission on Governmental Accountability and Forecasting in November that we were embarking on this plan of closing a State-operated developmental facility and two State psychiatric hospitals. We developed that plan and announced it more publicly in January, as I said in my remarks, and so this has been going on for more than nine months, and although that might be a quick turnaround for some efforts, given the financial urgency of the State, and we're being urged by many people in this room and elsewhere across the state to do a better job with our finances, nine months of planning and effort, I think, is not -- with those nine months, I don't think it's fair to say that we're moving on this too quickly, given all of the other demands on the money and especially the opportunity for the 7.3 million to be used in these very worthy community assets for further development.

MR. PENN: On a question about the employees, you said that they have the right to move. Do you know if all of these hospitals that you listed have a unionized work force, like AFSCME, where they have to come in and apply, or would they have to be reapplying for work outside of their Union Collective Bargaining Agreement? And how many of these hospitals that you listed are for-profit

hospitals?

MS. FERGUSON: I'll let Mr. Pelletier answer the second half of your question.

For the first part, Member Penn, the opportunities that I was speaking of are State opportunities or vacancies or bumping opportunities that are within State employment. I'm not sure how many of the community agencies or hospitals that we're contracting with have Collective Bargaining Agreements. I simply don't know. We can find that out.

MR. PELLETIER: None of the hospitals that we are contracted with are for-profit.

VICE-CHAIRMAN HAYES: I'd like to recognize Member Sewell.

MR. SEWELL: This $7.3 millions is a fiscal '13 amount of money, is that correct, that will be there for enhanced community services?

MS. FERGUSON: I'm sorry. That's an annualized number. I think the number for FY '13 is 4.6.

MR. SEWELL: Okay. So, will the Administration be advocating for money for enhanced community services going forward, like FY '14 or '15?

MR. GELDER: Yes.

VICE-CHAIRMAN HAYES: Yes. I'd like to

recognize our General Counsel, Frank Urso -- I'd like to first recognize David Carvalho.

MR. CARVALHO: Thank you, Chairman.

Just listening to the presentation so far, just two things with respect to the rules and structure of the process that I probably should note for members. First -- and Michael can correct me if I'm wrong -- I don't believe employment or jobs is listed in your statute or your rules as a consideration one way or another on applications. Is that correct, Mike?

MR. CONSTANTINO: That's correct.

MR. CARVALHO: Second, one of the things that you have seen over the years, especially those of you who have been here for a number of years, is your slice of what goes on in the healthcare marketplace is narrow and what you have jurisdiction over and what you don't, which is part of the reason why a couple of years ago, there was a introduction into the statute and the creation of a Center for Comprehensive Health Planning, so that that Center could look at the whole picture and then advise you on how your slice of it fits into it. How is that relevant? As we see both government and private healthcare providers in the -- and the marketplace as a whole shift the way the care is provided from institution to outpatient or from

institution to community-based providers, you regulate the institutional side of things, but you don't regulate the outpatient or the community side. You don't collect data on the community side. We don't factor in what goes on in the community side as a counter-balance to what is not happening on the institutional side, if that movement takes place.

So, for example, if there was absolute consensus in the mental health community that all care should be provided on an outpatient basis, then -- just do that, because the math is easier -- and there was an abundance of resources to do so, every analysis by your Staff would say that's negative, because the movement of that care from inpatient to outpatient reduces the inventory of inpatient services, and, since that's the only component of healthcare that you track and the only component that you identify a need for, anything that reduces that inpatient side and the resources devoted to that inpatient side will automatically result in a negative finding, because there is no crediting, because you don't regulate it and you don't keep track of it, of the care being provided on the outpatient side. You recall this has come up when the issue of cancer care was discussed a couple of -- maybe it was a year ago, where you don't have

information about cancer care being provided on an outpatient basis, and so any addition or subtraction on the inpatient side, you're looking at in isolation. It comes up when we rebalance on the nursing home side. There is -- there are all sorts of care outside of nursing home that you don't account for -- assisted living, in-home care. None of that gets accounted for in the analysis.

And so your need is focusing on the inpatient side, and then, of course, it comes up today, because the analysis that our Staff did on need looks only at how is this affecting inpatient supply. But we don't regulate the outpatient supply. We don't account for it. There is no way to credit in the analysis.

So, that's a reminder of one of the inherit features of the CON process as currently structured, and we have a continued hope that we can set up the Center for Comprehensive Planning as soon as there is some funding for it.

VICE-CHAIRMAN HAYES: Thank you, David.

Any other comments.

Now I'd like to recognize our General Counsel, Frank Urso.

MR. URSO: Thank you, Mr. Chair.

The chair has asked that I describe the

possible options that you have as a Board when you're considering this particular project. So, first option is, you can approve this application. Second option is, you can approve this application with conditions that would have to be expressly agreed to by them. You can deny this particular application, and they'd be receiving an Intent to Deny, and they have an opportunity to come back before this Board. And the fourth one is, there could be a deferral. The project could be deferred, if the Board sought to do that. So, those are the options that are available as you consider this particular project.

Thank you.

VICE-CHAIRMAN HAYES: Do we have any more -- do we have any more Board questions?

(Pause)

VICE-CHAIRMAN HAYES: Seeing none, I'd like to move to do a motion to approve this project.

MS. OLSON: So moved.

MR. SEWELL: Second.

VICE-CHAIRMAN HAYES: First, I'd like to make the -- may I have a motion to approve Project 12-060 to authorize the discontinuation of the 76-bed AMI facility in Rockford, Illinois?

MS. OLSON: So moved.

MR. SEWELL: Second.

VICE-CHAIRMAN HAYES: Roll call.

MR. PENN: Let me clarify this. A yes vote is we're closing the facility, and a no vote is it stays open?

VICE-CHAIRMAN HAYES: Yes.

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

Dr. Burden?

MR. BURDEN: I want to understand what the motion applies. We're voting now to close the institution? Is that what I heard? You're not adding anything to this motion that allows us to consider an Intent to Deny or deferral? Am I right?

VICE-CHAIRMAN HAYES: Yes, this is a motion to close this institution.

MR. BURDEN: I vote no.

MR. ROATE: Senator Demuzio?

MS. DEMUZIO: Yes.

MR. ROATE: Mr. Eaker?

MR. EAKER: For the concerns that I expressed earlier, I vote no.

MR. ROATE: Justice Greiman?

MR. GREIMAN: I vote -- I'm concerned about

the closure of it, but I also feel that we have a whole philosophy of saving government funds and reducing our costs. So, I'm going to vote aye.

MR. ROATE: Ms. Olson?

MS. OLSON: Yes.

MR. ROATE: Mr. Penn?

MR. PENN: I'm going to vote no for the concerns I have.

MR. ROATE: Mr. Sewell?

MR. SEWELL: Yes.

MR. ROATE: Chairman Hayes?

VICE-CHAIRMAN HAYES: I'm going to vote yes.

MR. ROATE: Five votes in the positive, three votes in the negative.

VICE-CHAIRMAN HAYES: The motion is approved. Thank you very much.

(Pause)

VICE-CHAIRMAN HAYES: You will be receiving -- you'll be having reporting requirements, and the Staff will follow up with you on that.

MS. FERGUSON: Thank you very much.

MR. CONSTANTINO: Mr. Chairman, a bit of housekeeping. We had two letters of comment on the State Agency Report that was e-mailed to you, and they were

responsive, I believe, and we need the Board's approval to put them into the record.

VICE-CHAIRMAN HAYES: Okay. I'd like to have a motion to be able to accept the letters on the State Agency Report for Project 12-060.

MR. CONSTANTINO: That's correct.

MS. OLSON: So moved.

MR. SEWELL: Second.

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

Dr. Burden?

MR. BURDEN: Yes.

MR. ROATE: Senator Demuzio?

MS. DEMUZIO: Yes.

MR. ROATE: Mr. Eaker?

MR. EAKER: Yes.

MR. ROATE: Justice Greiman?

MR. GREIMAN: Yes.

MR. ROATE: Ms. Olson?

MS. OLSON: Yes.

MR. ROATE: Mr. Penn?

MR. PENN: Yes.

MR. ROATE: Mr. Sewell?

MR. SEWELL: Yes.

MR. ROATE: Chairman Hayes?

VICE-CHAIRMAN HAYES: Yes.

MR. ROATE: That's eight votes in the affirmative.

VICE-CHAIRMAN HAYES: Thank you. Now, I'd like to adjourn for lunch. We will be back here in 45 minutes. So that will take us to 1:35.

(Recess)

VICE-CHAIRMAN HAYES: I'd like to call the meeting back to order, and we're going through Item 15 of the agenda, Applications Subsequent to Initial Review, and our next project is 12-043, Fresenius Medical Care West Belmont. I understand there is no public comment there. Could I invite the applicant up to the table here?

(Pause)

VICE-CHAIRMAN HAYES: Now, if you could introduce yourselves and spell your name, and then also, if we could have a collective swearing in.

MR. STOTZ: Rick Stotz (spells name).

MS. RANALLI: Clare Ranalli (spells name).

MS. WRIGHT: Lori Wright (spells name).

(Oath given)

VICE-CHAIRMAN HAYES: Mike, could we have a Staff report?

MR. CONSTANTINO: Thank you, Mr. Chairman.

This project -- the applicants are proposing to add four stations to a 13-station facility for a total of 17 ESRD stations, at an approximate cost of $845,000. This project did not have any findings or any opposition.

Thank you, Mr. Chairman.

VICE-CHAIRMAN HAYES: Thank you, Mr. Constantino.

And we have the applicant.

MR. STOTZ: Good afternoon. My name is Rick Stotz, and I'm the Regional Vice-President for Fresenius Medical Care, overseeing the West Belmont facility. The West Belmont facility meets all of the State Board's Criteria. We'd be happy to answer any questions you might have.

(Pause)

VICE-CHAIRMAN HAYES: Does any Board member have any questions?

(Pause)

VICE-CHAIRMAN HAYES: Okay. Do I see any questions?

(Pause)

VICE-CHAIRMAN HAYES: Mr. Carvalho?

MR. CARVALHO: Can I just ask one question,

and it's not to the application, but it's following up.

Mike, if tomorrow, you know, like half of end-stage renal dialysis patients start getting their dialysis with home care -- which is apparently the way of the future and the way a lot of people would like to see it handled, and/or transplant -- but say home care. Does our need formula in any way auto adjust, or are we going to have to do some adjustment so we don't keep building end-stage renal dialysis centers?

MR. CONSTANTINO: All the data we are collecting right now is for the end-stage dialysis. That's all we're collecting, David.

MR. CARVALHO: What I was getting at, some of our formulas kind of auto correct. We've talked about how the -- issue about changing demographics in a community, such as one in Bolingbrook, where the Hispanic population was going up, so the need was going to go up, but because we base our need on data on actual use, actual use will go up, so the formula will go up. I refer to that as auto correcting. Will we auto correct if more people are receiving home care and therefore presumably the utilization goes down?

MR. CONSTANTINO: That would probably be the case.

MR. CARVALHO: So we don't have to worry that we're over building these things, even though more people are going towards home care?

VICE-CHAIRMAN HAYES: Dr. Burden?

MR. BURDEN: Along the lines of what Mr. Carvalho said, you at Fresenius are in a position to probably comment on it. What is the possibility of greater treatment, which I guess would be -- I don't know how you would handle hemodialysis at home, but we're talking about peritoneal dialysis becoming a bigger part of the picture. Is that a realistic probability?

MR. STOTZ: It is, and we're working to that end. We're trying to get patients on home. CMS is asking us to look at that. Patients that are appropriate for home care, we certainly are offering that. Physicians are moving in that direction. So we're absolutely trying to have patients go home. Some fail home therapies and end up back in center. There are modality options there. It's either home hemodialysis as well as peritoneal dialysis.

MR. BURDEN: It strikes me that it would be impossible to do hemodialysis anywhere but at an institution. I just wonder if the day may ever come. Who knows what the future may bring? But I think -- I haven't heard that discussion Mr. Carvalho brought up, but it's

interesting.

MR. STOTZ Unfortunately, we're a long way from having 50 percent of our patients on home therapies. That would be ideal, but we're struggling to get 12 percent on home therapies.

MR. BURDEN: Thank you.

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

(Pause)

VICE-CHAIRMAN HAYES: May I have a motion to approve Project 12-043, to authorize the addition of four ESRD stations to an existing end-stage renal dialysis facility in Chicago, Illinois?

MR. EAKER: So moved.

MR. SEWELL: Second.

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

Dr. Burden?

MR. BURDEN: Yes.

MR. ROATE: Senator Demuzio?

MS. DEMUZIO: Yes.

MR. ROATE: Mr. Eaker?

MR. EAKER: Yes.

MR. ROATE: Justice Greiman?

MR. GREIMAN: Yes.

MR. ROATE: Ms. Olson?

MS. OLSON: Yes.

MR. ROATE: Mr. Penn?

MR. PENN: Yes.

MR. ROATE: Mr. Sewell?

MR. SEWELL: Yes.

MR. ROATE: Chairman Hayes?

VICE-CHAIRMAN HAYES: Yes.

MR. ROATE: Eight votes in the affirmative. The motion passes, and you'll be receiving information from the Board on your reporting requirements. Thank you very much.

Now, our next project is Project 12-029, BMA Southwestern Illinois, Alton. Could I have the applicants at the table here? I understand there is no public comment.

(Pause)

VICE-CHAIRMAN HAYES: So, could I have you say and spell your name for the Court Reporter, and then she will have a group swearing-in.

MS. BIRKENMEIER: My name is Kim Berkenmeier (spells last name)

MS. RANALLI: Clare Ranalli (spells last name)

and Lori Wright (spells last name).

(Oath given)

VICE-CHAIRMAN HAYES: Mike, can I have a Staff report?

MR. CONSTANTINO: Thank you, Mr. Chairman.

The applicants are proposing to discontinue a 19-station ESRD facility and establish a 19-station facility, located in 12,043 gross square feet of leased space in Alton, Illinois. The approximate cost of the project is $4.4 million.

Thank you, Mr. Chairman.

VICE-CHAIRMAN HAYES: Thank you.

Applicant, would you like to address the Board?

MS. BIRKENMEIER: Yes. Good morning. I would like to thank the Board for the review analysis of our project, and I am here representing Southwestern Illinois Dialysis Center. I am the Area Manager for that facility.

We have been serving the Alton community for 26 years, and during that time, our current site is in an area that has become increasingly industrial and we have become subject to frequent vandalism at our site. Our building itself is in a strip mall that is becoming rundown, and the common area, such as the parking lots and

sidewalks, are also showing considerable wear and tear.

We realize that we are not operating at the Board's standard of 80 percent, based on three shifts. With the rural nature of our facilities, the majority of rural dialysis centers do not operate three shifts. We operate two shifts, and we are at 76 percent utilization operating on those two shifts. We find that our patients do not want to be transporting late at night. 35 percent of our patients do take Medicaid or disability transportation that does not run into the late night hours, and others of our patients rely on family members to transport them. The ones that do drive themselves do not want to be out on the rural, country roads late at night, especially in inclimate weather.

By relocating to our new location, we do believe our utilization will improve, as it will be easy access for the patients to get to us. We will also be able to expand the home therapy options, which were just being discussed a moment ago, and to add a nocturnal shift which is something that is growing in the dialysis environment and we simply do not have the space to do that in our present location.

Our staff at Southwestern Illinois Dialysis Center have been with us for an average of 13 years. We

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have long-term, dedicated staff, who have firmly established relationships within the community and with our patients. We are also a leading quality provider in the market. The Illinois Renal Network publishes statistics based on quality output, and we consistently lead both the Network and the state of Illinois in our quality outcomes, and for the past 11 months, we have also been in the top 10 percent of Fresenius Medical Care North America for our Fistula First initiative for our patient access.

So, on behalf of our Staff and our patients, I would like to thank you for considering our relocation today, and we would appreciate it if we could have it approved, please.

VICE-CHAIRMAN HAYES: I'd like to open up for Board questions.

Dr. Burden?

MR. BURDEN: I'm curious about what are your quality outcomes?

MS. BIRKENMEIER: We measure adequacy, anemia, albumin, phosphorus, and percentage of patients who do not have catheters as our key indicators. Our outcomes for the most recent month had 94.4 percent of our patients achieving an adequacy greater than 1.2 percent. We had 76.4 percent of our patients with an anemia outcome between

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10 and 11; 49.1 percent of our patients with an albumin greater than 4; 72.7 percent of our patients with a phosphorus between 3.0 and 5.0, which is the top 10 percent within Fresenius North America, and 85.5 percent of our patients without a catheter.

MR. BURDEN: Is this considered material that is routinely done by all dialysis units that are in the state of Illinois, or is this just Fresenius that does this quality outcome study?

MS. BIRKENMEIER: I believe all the dialysis providers monitor quality outcomes. I'm not familiar with their processes, to know exactly if the monitors are the same.

MR. BURDEN: Thank you.

VICE-CHAIRMAN HAYES: Any other -- I'd like to recognize Member Penn.

MR. PENN: I'm curious for the need for 19 stations. I'm looking at Table Four on page 5, and there's five other facilities listed, and none of them meet State standard. So, to argue that you need 19 -- I understand you're closing 19 and setting up 19, but could you comment on that?

MS. BIRKENMEIER: Yes. I link that back to what we were saying earlier with the rural facilities not

traditionally operating three shifts. Most of the rural dialysis centers do operate two shifts, and with 19 stations at two shifts, we are currently at 76 percent utilization, and the third shift not being run is really driven by our patients not wanting to be out, exposed in the night to the rural, country roads and the lack of transportation options for our patients that do require the Medicaid and the disability transport.

MS. OLSON: So, in other words, if you took that third shift out of all of those facilities, their utilization wouldn't be much higher because nobody is using that third for the reasons you stated?

MS. BIRKENMEIER: Correct. The majority of rural facilities do not operate that third shift.

VICE-CHAIRMAN HAYES: You know, I have a question. You know, basically this facility has been around what, 26 years?

MS. BIRKENMEIER: Yes.

VICE-CHAIRMAN HAYES: Okay. And originally how -- the Board approved this for how many stations?

MS. BIRKENMEIER: Oh, I apologize. That was way before my time. I would have to be -- I would have to look up an answer to give you a correct answer.

MR. CONSTANTINO: It was approved for 12

stations.

VICE-CHAIRMAN HAYES: It was approved for 12 stations.

MS. BIRKENMEIER: Thank you.

VICE-CHAIRMAN HAYES: So, over the years, have you ever come back to the Board for your additional 7 stations, or have you been, through our Rules, adding stations as you went along.

MS. BIRKENMEIER: It was been through the rules.

VICE-CHAIRMAN HAYES: I see. Okay.

MS. BIRKENMEIER: The addition every two years.

VICE-CHAIRMAN HAYES: Okay.

MS. WRIGHT: Most rural clinics will add stations even though they're not at 80 percent, according to the two-year rule, because they try to keep the patients on the first two shifts of the day. So, you'll see -- that's why you see a lot of clinics, their stations go up, their utilization doesn't, because they're keeping the patient on those two shifts, those first two daytime shifts, and if we were to reduce stations, then what we'd have to do is take those patients who are now on the first two shifts of the day, some of them would have to go to the

third shift, which is about eight o'clock at night. There's very limited transportation. They don't want to be out on the roads at night.

VICE-CHAIRMAN HAYES: Now, if -- you mentioned that in this new facility, you'd like to have -- you'd like to go to three shifts, you'd like to have a nocturnal shift.

MS. BIRKENMEIER: Yes. Nocturnal dialysis is something that is growing as an option among the patients in the dialysis community. They actually dialyze for an 8 to 10-hour time frame. They can be dropped off by family members, have a long, slow dialysis process, and then be picked up the next morning by their family members. So, it does -- it's an opportunity that's growing as a new treatment option for patients, and there isn't a service of that kind right now in the market.

MS. OLSON: That's different than the third shift?

MS. BIRKENMEIER: Correct.

VICE-CHAIRMAN HAYES: And because of the time involved in dialysis, 8 to 10 hours?

MS. BIRKENMEIER: Yes. A traditional third shift patient would run anywhere from 3 to 4 hours, depending on the physician's prescription, and that's where

we get into the transportation challenge with patients trying to get transportation home or actually trying to transport them between 8:00, 9:00, sometimes 9:30 at night on the rural, country roads.

VICE-CHAIRMAN HAYES: Now, I want to compliment you on the nocturnal dialysis program. We've talked about that as a Board quite a bit. I was just wondering, did you ever look at the option of having less stations to be able to utilize the facility better?

MS. BIRKENMEIER: We did look at that, but it came back to the transportation issues again for our patients. If we did reduce the stations, we would have those patients -- and run third shifts, the patients would be getting out at 7:00, 7:30, 8:00 o'clock at night and trying to transport themselves, and we also, with our particular patient population, run into 35 percent of our patients that would have to be on the first and second shifts because of the Medicaid and the disability transportation. So, it would really limit the patients that could go onto those third shifts. They would have to be our patients that either drove themselves or had family members, and there would be challenges with getting that transportation set up.

VICE-CHAIRMAN HAYES: Okay. Thank you very

much.

MS. BIRKENMEIER: Thank you.

MR. PENN: Do you agree with that comment that if the third shift was factored out, that utilization would meet the State standards?

MR. CONSTANTINO: Yes.

VICE-CHAIRMAN HAYES: Any other Board member like to ask a question?

(Pause)

VICE-CHAIRMAN HAYES: Seeing none, I'd like to move to a motion. May I have a motion to approve Project 12-029 to authorize the discontinuation and reestablishment of a 19-station ESRD facility in Alton, Illinois?

MS. DEMUZIO: So moved.

MS. OLSON: Second.

MR. ROATE: Motion made by Senator Demuzio, seconded by Ms. Olson.

Dr. Burden?

MR. BURDEN: Yes.

MR. ROATE: Senator Demuzio?

MS. DEMUZIO: Yes.

MR. ROATE: Mr. Eaker?

MR. EAKER: Yes.

MR. ROATE: Justice Greiman?

MR. GREIMAN: Yes.

MR. ROATE: Ms. Olson?

MS. OLSON: Yes.

MR. ROATE: Mr. Penn?

MR. PENN: Yes.

MR. ROATE: Mr. Sewell?

MR. SEWELL: No. Occupancy and unnecessary utilization.

MR. ROATE: Chairman Hayes?

VICE-CHAIRMAN HAYES: I'm going to vote no, because of the reasons so stated, and specifically the project utilization and the Planning Area need criteria.

MR. ROATE: Thank you, sir. Six votes in the affirmative, two votes in the negative.

VICE-CHAIRMAN HAYES: Motion passes, and you'll be receiving information on your reporting requirements from the State Board Staff. Thank you very much.

(Pause)

VICE-CHAIRMAN HAYES: The next project here is Project 12-034, DaVita Red Bud Dialysis, Red Bud. Could I have the applicant come to the table?

(Pause)

VICE-CHAIRMAN HAYES: And if you could -- the applicant, if they could state their name and spell their name for the Court Reporter, and then be -- have a swearing in, a mass swearing in.

MS. EMLEY: Cindy Emley (spells name).

MS. FRIEDMAN: Kara Friedman and Anne Cooper from Polsinelli Shughart.

(Oath given)

VICE-CHAIRMAN HAYES: Mike, State Staff report?

MR. CONSTANTINO: Thank you, Mr. Chairman. The applicants are proposing an 8-station facility in 6,000 gross square feet of leased space in Red Bud, Illinois. The cost of the project is approximately $2.4 million. The anticipated project completion date is December 31st, 2014. There was a public hearing held on this. No letters of opposition were received.

Thank you, Mr. Chairman.

VICE-CHAIRMAN HAYES: Thank you, Mr. Constantino.

The applicant, would they like to make some comments to the Board?

MS. EMLEY: Yes, please. Good afternoon. My name is Cindy Emley. I'm the Regional Operations Director

from DaVita, and with me today are my representatives from Polsinelli Shughart that assisted me with the CON application. I would really like to thank the Health Facilities Review Board for the opportunity to explain why a dialysis facility is needed in Red Bud.

The purpose of this project is to provide access to life-sustaining dialysis to the residents of southwestern Illinois. We selected Red Bud, because it's predominantly a rural area with no dialysis facilities within 30 minutes and where many patients of Dr. Dalal have good access to planned location. As stated in the patient support letters submitted for this project, the proposed Red Bud Dialysis is centrally located to patients who reside in Red Bud, Sparta, Waterloo, and who must currently travel over 40 minutes for their dialysis. Furthermore, the project has received the support of the community. A public hearing was held on the project. 27 people attended, and no one testified or registered in opposition to the project.

The proposed Red Bud facility will be located in Health Service Area 5. It's important to understand, this Planning Area encompasses most of southern Illinois, which is predominantly rural. Health facilities -- healthcare facilities in rural areas generally do have

lower utilization rates than those in urban areas. This is due partly to the lower population densities. Although they serve a large geographic area, rural facilities have a smaller population base to draw from. As a result, utilization is generally lower in the -- lower than urban facilities.

Increasing access to dialysis by approving a facility in Red Bud will not increase utilization. Importantly, only those patients who are in kidney failure and require dialysis are referred to dialysis. Moreover, patients do not receive more than the standard number of treatments, which is three times per week. Increasing utilization is not indicative of a referral problem but rather the increasing incidents and prevalence of ESRD, which is due in significant part to the increasing rates of diabetes and hypertension in the general population, as well as the decreasing attrition rates due to earlier intervention and improved treatment.

Further, approval of this proposed Red Bud facility will not result in increased costs to the government or to other payers. On January 1 of 2011, DaVita implemented the Medicare's new bundle payment system. Under this new reimbursement system, DaVita is paid a fixed payment rate to cover all goods and services

provided during dialysis treatment, including pharmaceutical and lab costs that historically were reimbursed separately. As a result of this fixed payment system, as well as based on the nature of dialysis, there is no incentive for a dialysis provider to provide an unnecessary treatment.

Thank you for your time and attention, and I really respectfully ask you to approve the Red Bud project. Thank you.

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

MR. PENN: The only question I have is about the square footage, in excess of State standards, gross square feet.

MS. EMLEY: Yes. Approximately 1,500 square feet of that would be for us to provide home dialysis services, and then the rest of it would be for the in-center treatments.

MR. PENN: So you're saying that this extra 1,840 gross square feet is to help you provide home services?

MS. FRIEDMAN: That's right, and if you look at the statute and understand, home dialysis isn't really -- the training facilities aren't really part of the

legislative framework, so, typically, you're not even analyzing that space, and that's why it's showing as an excess, because you really don't consider it.

MR. BURDEN: I have a question.

VICE-CHAIRMAN HAYES: Dr. Burden.

MR. BURDEN: This area is rural. Where does it -- excuse me for being ignorant of my state. Where is the area of Little Egypt? In your community or further south?

MS. EMLEY: Is that around Cairo? That's way south, I believe.

MR. BURDEN: Further south?

MS. EMLEY: Yeah, further south.

MR. BURDEN: My prior extensive time was sitting on a committee that for 15 years I looked at all of the alleged malpractice in the state of Illinois. Employed Plaintiffs' attorneys in your area made a steady trip up to Chicago regularly and usually came up in big fancy cars. I mean, I'm impressed when you tell me about the rural community and, essentially, I imagine it's a large Medicaid population in your community. Am I right or wrong on that?

MS. EMLEY: That's correct.

MR. BURDEN: A long trip between -- I mean, there's already an excess of beds, but you're pointing out,

a trip for the folks you're attempting to treat are traveling 30 minutes plus?

MS. EMLEY: Yes.

MR. BURDEN: And that's rural driving?

MS. EMLEY: Correct, two-lane roads.

MR. BURDEN: Normally I would be a little concerned about -- when there is no need for stations, but your operation appears to be located in an area where there -- that's essentially going to happen. I mean, there's no way for them to not travel this distance, unless we approve your application. Is that what I'm seeing?

MS. EMLEY: That's correct.

MR. BURDEN: How long has it been this way, that the patients in the community that you are attempting to serve have this--

MS. EMLEY: The closest area that we have right now is, they've been coming up into the Fairview Heights market, or if they travel down in the Chester market, it's probably well into, you know, 40 minutes or so from there.

MR. BURDEN: You get a little snow in the winter time?

MS. EMLEY: We do.

MR. BURDEN: That's enough. Thank you.

VICE-CHAIRMAN HAYES: I'd like to recognize member Justice Greiman.

MR. GREIMAN: Yes. Thank you.

I was just noting your charitable -- charity care you have, which is particularly small. What is it, .59? 23 percent, it looks like. So, previously we have imposed upon you folks the obligation to tender doctors that will take charity cases, and that was a condition we previously put on it, and I would hope the Committee would put -- would impose that upon you again, that you have to tender doctors that would take charity cases. Is that --

MS. FRIEDMAN: I think I -- if there -- if there could be a condition on the permit, I guess I do have to understand it. We do make a lot of postings of information for our medical staff about the policies and, of course, they're required to read the policies and procedures. So, if we continue to do that in our facilities --

MR. GREIMAN: The issue is that they don't come to you. You're not the first person that the patient comes to. He goes to his doctor first, and the doctor has to tell them, "You can get a free meal over there."

MS. EMLEY: Well, I do know that at DaVita, as the Regional Director, we get patients all the time that

have absolutely no insurance, and we say yes to every patient, and we just --

MR. GREIMAN: You have no objection to imposing a condition that you would tell your doctors that? That would be okay with you?

MS. EMLEY: I mean, the physicians take all -- down in that particular area, Dr. Dalal is typically the physician that the -- that takes all the charity care. I have no worries about. I have no problems with that at all, none whatsoever, because that's really what we're doing now.

MR. GREIMAN: Okay.

MR. URSO: So, you agree to a condition being placed on this permit that you will take all charity cases, is that what -- that they will take all patients regardless of their ability to pay? Is that your condition.

MR. GREIMAN: Well, they will tell their doctors.

MR. URSO: And notify their doctors. And do you want them to report back at any specific time, back to the Board as to their compliance with this?

MR. GREIMAN: Six months or so is fine.

MR. URSO: Every six months?

MR. GREIMAN: Yeah.

MR. URSO: Do you agree to that?

MS. FRIEDMAN: With regard to the notification of the physicians, I would suggest that we submit a letter that documents the communication that we're making, and then on an annual basis, we'll be reporting through the Survey the data.

MR. URSO: No, that's not how the Justice said it. He wants you to report back to the Board every six months.

MS. FRIEDMAN: So, the date would be every six months instead of twelve months?

MR. URSO: That's what the Judge wants.

MS. FRIEDMAN: For this facility, that's fine, yes.

MS. OLSON: I don't think I understand it. Do you understand?

MS. FRIEDMAN: I believe what he's asking is for documentation that we're notifying physicians and that we report our charity care data every six months instead of every twelve months.

MS. OLSON: But is six months necessary? We can't do it in twelve months?

MR. GREIMAN: If the Board feels -- if a year is fine, that's fine, if that is easier.

MS. OLSON: I just think -- how many of these in the state? If we ask all of them to report every six months --

MR. GREIMAN: You're right and why should they -- I think 12 months, every 12 months.

MR. CONSTANTINO: We have a mechanism also set up for an annual report.

MS. OLSON: Right. I think that's --

MR. URSO: So, do you agree with the annual report?

MS. EMLEY: Yes. Thank you.

VICE-CHAIRMAN HAYES: Are there any more -- Member Sewell.

MR. SEWELL: I hate to belabor this point. I guess I don't understand the first part. Now, you're asking the -- I'm talking to Justice Greiman, by the way. You're asking the applicant to notify their physicians that if patients don't have the ability to pay, they can still bring them to this facility?

MR. GREIMAN: Right, exactly.

MR. SEWELL: Okay. But you're not setting a target that they have to achieve?

MR. GREIMAN: No.

MR. SEWELL: Okay. I understand that. Thank

you.

MR. GREIMAN: Just so when the doctor gives a prescription, he knows it's going to be filled someplace.

MR. URSO: Does the applicant understand?

MS. EMLEY: Yes.

MR. URSO: And they agree?

MS. EMLEY: Yes.

VICE-CHAIRMAN HAYES: Is there any other questions from the Board?

(Pause)

VICE-CHAIRMAN HAYES: All right. Well, I'd like to be able to make a motion to approve Project 12-034, to authorize the establishment of an 8-station ESRD facility in Red Bud, Illinois, with the condition that, basically, you will continue the policy of charity care, that all comers will receive charity care, that you will notify your doctors of that policy, so they can refer patients that need it to your facility, and that you'll be reporting that on the normal reporting cycle of one year.

MR. EAKER: So moved.

MS. DEMUZIO: Second.

MR. SEWELL: Mr. Chairman, discussion on the motion before we move?

VICE-CHAIRMAN HAYES: Okay. I recognize

Member Sewell.

MR. SEWELL: There's a part in there where the phrase "all comers" was used. And I don't think that's what Justice Greiman asked for, but I could be wrong. But I don't support the requirement that they take all comers. So, I just need clarity on that. My understanding was that they were to notify the physicians that work with them, that make referrals to them, that they would be a resource for patients that did not have a source of payment. All comers is a little too wide open there.

MR. GREIMAN: That's -- you know, people don't go in there without a doctor's statement. So, that's what they have to have, a doctor's statement. I can't go in to -- and say, "okay I'd like to have a little renal action." I can't say that. The doctor has to give me a prescription.

VICE-CHAIRMAN HAYES: Well, I have no -- to amend the condition for that --

MR. SEWELL: I'd like to take the phrase "all comers" out of that.

MR. GREIMAN: That's fine with me. Whatever.

VICE-CHAIRMAN HAYES: I was specifically talking about your charity care policy. So, basically, even if they did come without a doctor's prescription, you

would still treat them, in the rare circumstance.

MS. EMLEY: No, we can't. What typically happens is that the physician refers the patient to us, gives us orders to do their dialysis treatment, and during that time, we are checking with the patient, everything -- getting them with a social worker, finding out whether they have an insurance plan of any kind, Medicaid, Medicare, a private insurance or even secondary insurances. There's very few patients that don't get one type of insurance. Most of them -- 80, 85 percent of them are Medicare, and then the rest of them are some other payor mix. So, it's rare that we would not have someone -- some insurance for a patient.

MS. FRIEDMAN: And just with the specific request with respect to what Mr. Greiman said, you have to have a prescription for dialysis from a physician. So we would not admit a patient unless we had that prescription. So, I think the issue is, we will notify physicians that we will accept patients, regardless of their ability to pay, which is different than all comers. Thank you.

VICE-CHAIRMAN HAYES: Okay. Then I'll try that motion again. May I have a motion to approve Project 12-034 to authorize the establishment of an 8-station ESRD facility in Red Bud, Illinois, that no patient will be

turned away because of the ability to pay, and that you will notify your physicians of that, that no patient will be turned away because of inability to pay.

MR. EAKER: So moved.

MR. GREIMAN: Second.

VICE-CHAIRMAN HAYES: So moved and seconded. May I have a roll call?

MR. ROATE: Motion made by Mr. Eaker, seconded by Justice Greiman.

Dr. Burden?

MR. BURDEN: I'm going to vote yes, even though I recognize there's no calculated need for more stations in the area. There's a great travel distance problem in this rural community, and I think that allows me to feel personally that I will vote yes.

MR. ROATE: Senator Demuzio?

MS. DEMUZIO: Yes.

MR. ROATE: Mr. Eaker?

MR. EAKER: Yes.

MR. ROATE: Justice Greiman?

MR. GREIMAN: Yes.

MR. ROATE: Ms. Olson?

MS. OLSON: Yes.

MR. ROATE: Mr. Penn?

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MR. PENN: Yes.

MR. ROATE: Mr. Sewell?

MR. SEWELL: No. Excess capacity.

MR. ROATE: Chairman Hayes?

VICE-CHAIRMAN HAYES: Yes.

MR. ROATE: Seven votes in the affirmative, one vote in the negative.

VICE-CHAIRMAN HAYES: Motion passes, and you'll be receiving a letter from our State Board Staff to that effect. Thank you very much.

(Pause)

VICE-CHAIRMAN HAYES: Now, let's go to the next project, Project 12-046, Fresenius Medical Care Spoon River, Canton.

(Pause)

VICE-CHAIRMAN HAYES: I guess it would be the applicant, if they could state their name and spell their name, and then we'll have a swearing in.

MR. STOTZ: Rick Stotz, Clare Ranalli, and Lori Wright.

(Oath given)

VICE-CHAIRMAN HAYES: Mike, can we have a State report?

MR. CONSTANTINO: Thank you Mr. Chairman.

The applicants are proposing to discontinue an 8-station ESRD facility and establish a 9-station facility in approximately 6,000 gross square feet of leased space in Canton, Illinois. The cost of the project is $2.7 million. There was no public hearing, and no letters of opposition were received by the State Board Staff.

Thank you, Mr. Chairman.

VICE-CHAIRMAN HAYES: Thank you, Mr. Constantino.

The applicant, do you have a presentation for the Board?

MR. STOTZ: Yes, sir. Good afternoon. Again, my name is Rick Stotz. I'm the Regional Vice-President for Fresenius Medical Care, covering the Canton area. I want to thank the Board for reviewing the project, first of all.

This project is truly a relocation of an existing facility with the addition of one isolation station for infectious patients, which we don't currently offer. This project meets all the Board's criteria, except for the size of the facility.

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

VICE-CHAIRMAN HAYES: I open it up for Board questions.

MR. GREIMAN: You were present at the last hearing?

MR. STOTZ: Yes, sir.

MR. GREIMAN: So, if we impose the same condition that we imposed on them, would you have an objection?

MR. STOTZ: No objections, no, sir.

MR. GREIMAN: Okay. Hopefully the Board will be agreeable to that, too. Thank you.

VICE-CHAIRMAN HAYES: Dr. Burden?

MR. BURDEN: I'm just curious. Where was Dr. Dryer sending his patients prior to this application? He has 53 something, a newfound source of patients in this rural community. Where were they going before?

MR. STOTZ: We have a facility in Canton that's in Graham Hospital and --

MR. BURDEN: I got you. He was going to the old facility.

MR. STOTZ: Yes, sir. The hospital wants the space back and they've given us until this summer to move out.

MR. BURDEN: As Regional Vice-President, do you have an economic interest in these facilities, or do you just supervise and make sure they're run properly?

MR. STOTZ: Just operation oversight.

MR. BURDEN: Thank you.

MR. PENN: How do you justify going out of the State standard for the square footage?

MR. STOTZ: Yes, sir. Basically, Graham Hospital is building on their campus the shell building for us. We wanted the ability to not have to come back to you for -- if we wanted extra stations. Also, we're considering the nocturnal program that was stated earlier, and the isolation station that we're adding requires more space than the standard station. So, we want to make sure, in essence, we have room to accommodate that station.

MR. CONSTANTINO: Yes, that's reasonable, David.

VICE-CHAIRMAN HAYES: Mr. Carvalho?

MR. CARVALHO: Thank you. Two questions to help clarify this caveat that's a condition that you and the other applicants have agreed to.

First, are undocumented persons eligible for any of the public payor sources, or would they be the persons who are likely to fall into the caveat?

MR. STOTZ: Emergency State Medicaid is available for them, if they have residency.

MR. CARVALHO: Emergency Medicaid?

MR. STOTZ: For dialysis only.

MR. CARVALHO: Normally, Emergency Medicaid is to go for an emergency, but dialysis is viewed as an emergency?

MR. STOTZ: It's life threatening.

MR. CARVALHO: Got it. Okay. So that's part of why either you or the prior applicants said there's very few people who slip between the cracks.

MR. STOTZ: That's correct.

MR. CARVALHO: Second, if upon notice from you to your doctors that you have this service available, even if a person has no payor source, the doctor will still have to take the patient and also not be paid, correct? I mean, you don't pay your doctors for sending people to you?

MR. STOTZ: Correct.

MR. CARVALHO: Okay. So, it will only operationalize if a doctor, having found this information out and finding a patient who isn't covered, both accepts -- takes that patient as their patient without payment and sends that patient to you, where you treat them without payment?

MR. STOTZ: Correct.

MR. CARVALHO: Okay. Thank you.

VICE-CHAIRMAN HAYES: Any other questions

from Board members?

(Pause)

VICE-CHAIRMAN HAYES: I'd like to go to a motion now. May I have a motion to approve Project 12-046 to authorize the discontinuation of an 8-station ESRD facility and the establishment of a 9-station replacement ESRD facility in Canton, Illinois? The applicant will continue to treat all patients, no matter their ability to pay, and that they will notify their physicians of this policy that they will treat all patients no matter their ability to pay. Can I have a motion?

MS. DEMUZIO: Motion.

MR. EAKER: Second.

MR. ROATE: Motion made by Senator Demuzio, seconded by Mr. Eaker.

Dr. Burden.

MR. BURDEN: Will my spoons that I use to catch fish catch fish in Spoon River?

MR. STOTZ: Certainly.

MR. BURDEN: I vote yes. Just kidding a little bit.

MR. ROATE: Senator Demuzio?

MS. DEMUZIO: Yes.

MR. ROATE: Mr. Eaker?

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MR. EAKER: Yes.

MR. ROATE: Justice Greiman?

MR. GREIMAN: Yes.

MR. ROATE: Ms. Olson?

MS. OLSON: Yes.

MR. ROATE: Mr. Penn?

MR. PENN: Yes.

MR. ROATE: Mr. Sewell?

MR. SEWELL: Yes.

MR. ROATE: Chairman Hayes?

VICE-CHAIRMAN HAYES: Yes.

MR. ROATE: That's eight votes in the affirmative.

VICE-CHAIRMAN HAYES: The motion passes, and you'll be receiving a letter from the State Board Staff, requiring -- or basically your normal reporting requirements. Thank you very much.

MR. GREIMAN: Mr. Chairman, it's my intention to make that motion every time we see them or DaVita here, and I would suggest that from now on, put it in your application, that one of the things you are going to do is treat charity cases. That is my suggestion.

VICE-CHAIRMAN HAYES: Thank you.

Our next project is Project 12-047, Fresenius

Medical Care, Plainfield North, Plainfield, Illinois. Now, I understand there is people for public comment here. We have five public comments, and if they could come up to the podium here, I will read your names. Bhuvan Chawla, Frankie Lanier Booth, Mary Phillips, and M. Garrigan.

Now, would each of you state your name for the Court Reporter, and then also, if you could describe, you're in support or in opposition to this project, if that's possible. So, we will start Bhuvan Chawla, M.D.

MR. CHAWLA: I'm in opposition.

VICE-CHAIRMAN HAYES: Okay. Your testimony?

MR. CHAWLA: Okay. Thank you, Chairman Galassie and the Board, for the opportunity to speak today. I am a Board-certified nephrologist and have been practicing in Joliet since 1981. I own and operate Sun Health Dialysis, which has been serving the community for over 20 years. As a practicing nephrologist, I'm intimately familiar with the challenges faced by dialysis patients. As a facility owner, I'm also intimately familiar with challenges facing the facilities in the face of duplication and maldistribution.

I am hereby requesting the Board to reject this application on the grounds that it is unneeded. It will not improve access, and will actually cause

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unnecessary duplication and maldistribution. The State Agency Report appears to be in agreement with this statement.

In the interest of respecting the Board's time, I have attached my previous letters of opposition to this letter, so I don't waste your time. My letters do outline the reasons that I feel this application should be rejected.

There are a couple of comments I'd like to make about duplication and maldistribution. Some of the situations when this occurs is when patients transfer from one facility to another. This application has letters from seven patients --

MR. MORADO: Thirty seconds.

MR. BHUVAN: -- who would like to move to another facility. Nursing home patients also move away from a dialysis facility. Like home dialysis, they're uncounted. I would, therefore, ask the Board to pay close attention to the issue of need and to vote no on this application.

Thank you.

VICE-CHAIRMAN HAYES: Thank you, Mr. Chawla.

Our next speaker will be Frankie Lanier-Booth.

MS. LANIER-BOOTH: Good afternoon. My name is

Frankie Lanier-Booth (spells name), and I'm here today because I'm a patient of Kidney Care Center located in Joliet, Illinois, and I took my own time off today from work and drove down from Joliet, because I am in support of approval of Fresenius Medical Care's request to expand and have a new project in Plainfield, Illinois.

After having some tests in June of 2007, my family physician revealed to me that my kidneys weren't functioning, or were functioning at about a 60 percent rate. There was nothing that I noticed that gave me any indication that I was having problems with my kidneys. I was immediately referred to Dr. Tunji Alausa, and he and his staff have been caring for me since 2007. Over the last five years, the continuity and coordination of care provided by Dr. Alausa, the team of physicians, and staff have enabled me to maintain the same level of kidney function as I had when I first came to the Kidney Care Center in 2007.

My main objective is to ensure that I do not have to go on dialysis. However, I am confident that if the need arises, that my quality of life and longevity would increase by the synergistic care provided by both the dialysis facility and the nephrologists. While I have not had to have dialysis, my father was a dialysis patient, so

I am well aware of the challenges that are incurred in this situation. I am aware of the decline that can go along with this type of treatment and believe that this new project in Plainfield will allow some patients to remain independent, which is very important when you're experiencing something like this.

MR. MORADO: Thirty seconds.

MS. LANIER-BOOTH: These patients drive to their appointments, and they'll be able to do that independently. So, once again, I want to say that I support this new project. Thank you.

VICE-CHAIRMAN HAYES: Thank you, Ms. Booth.

Our next speaker will be Mary Phillips.

MS. PHILLIPS: Hello. My name is Mary Phillips (spells name). I am a patient of Dr. Alausa and Dr. Shafi. I have been receiving dialysis at Plainfield for two years. I have received excellent care. Frankly, when I started dialysis, I had several clinics to choose. I chose his in Plainfield, which is closer to my home. Having the facility close to home matters a lot for somebody who is going -- coming to a facility three times a week, 365 days a year. Sitting on a dialysis chair for four hours for treatment makes you exhausted, and you want to go home quickly to rest. I don't have the stamina to

drive twenty, thirty minutes after treatment. Dialysis takes a toll on a person, as well as their family members. So, please, consider traveling distance to the dialysis center.

I was not asked to come here. I'm here on behalf of current and future patients of dialysis. They need another dialysis in Plainfield, because the current facility very soon will not be able to accommodate new patients. The staff at the dialysis center has worked hard to provide quality dialysis to me and many others at the Plainfield facility. It's because of them that I am alive. My doctors feel comfortable with --

MR. MORADO: Thirty seconds.

MS. PHILLIPS: -- them, and they will work as a team to provide me quality of life and many others. They treat us with respect and dignity.

I request the Board to approve this project and continue to serve us the way they have been doing for years. We don't want to experiment with other companies. Thank you.

VICE-CHAIRMAN HAYES: Thank you, Ms. Phillips.

Our next speaker will be M. Garrigan.

MR. GARRIGAN: Yes. Thank you, Mr. Chairman.

On behalf of -- my name is Michael Garrigan (spells name), the Village Planner for the Village of Plainfield. On behalf of the Village of Plainfield, I would like to reflect, Mr. Chairman, our continued support for the Fresenius Plainfield North facility. As you perhaps know, Plainfield has been one of the fastest growing, if not the fastest growing, communities in the Chicago metro area. Over the past 10 years -- specifically from 2000 to 2010 -- the Village saw well over 205 percent increase in population, from approximately 13,000 people to 40,000. We continue, Mr. Chairman, to be one of the most active communities in regards to residential developments, even in view of the major housing (unintelligible) we've all experienced over the past number of years.

The Village continues to grow, and, specifically, one of the most remarkable aspects specifically is to see the increased diversification of the community. Specifically, over the past 10 years, from 2000 to 2010, the Village has seen a remarkable growth rate of African American and Latino population, which has a critical access need for kidney dialysis. Specifically, the village has witnessed over 957 percent increase in African American and Latino population over the past 10 years, which basically outlines the need for kidney

dialysis.

We're over -- the current Fresenius Plainfield Facility South is in the City of Joliet. It is not in the Village of Plainfield. Based on the location, you can see there's approximately a three and a half mile distance between the current facility and the facility which is located in Plainfield. So, there is a critical need for this dialysis in, again, one of the fastest growing communities in the United States.

MR. MORADO: Thirty seconds.

MR. GARRIGAN: So, I would like to reiterate the Village's strong support for this Fresenius Plainfield North facility and looks forward to their future growth.

Thank you, Mr. Chairman.

VICE-CHAIRMAN HAYES: Thank you, Mr. Garrigan.

Our next speaker will be Dr. Shafi Mohammad.

MR. SHAFI: Thank you, Mr. Chairman. My name is Mohammad Shafi (spells name). I'm Board-certified in nephrology, critical care, and internal medicine. I represent a group of five doctors who specialize in kidney diseases.

There was a strong need for a dialysis center in Plainfield. Fresenius responded to that need by opening

a dialysis center in January 2010. The existing Fresenius facility in Plainfield achieved an 80 percent target utilization with one year of operation. The patients in the past had to travel 30 to 40 minutes to get dialysis. The quality indicators which we as nephrologists and Medicare monitor on a monthly basis have shown consistently that this center is achieving excellence in all parameters of dialysis, including improved outcome and mortality.

Now another facility is needed in Plainfield to meet the demand of the growing number of dialysis patients. There's also overwhelming public support for the Fresenius project. We have widespread support letters sent to the Board by Plainfield Mayor, Romeoville Mayor, Plainfield Village Administrator, House Republican leader, State Representative Tom Cross, Senator Linda Holmes, Will County Board member Brian Smith, President of Plainfield Chamber of Commerce Liz Collins, President of Bolingbrook Chamber of Commerce Mike Evans, Plainfield Director of Management Services Traci Pleckham, 12 dialysis patients and 7 Plainfield residents.

In closing, my patients want to do their dialysis close to home or work. The population in Plainfield, Illinois in general and dialysis patients in particular is growing. Patients currently have choices.

The experience of our doctors and patients with Fresenius has been excellent. They have proven themselves able to provide quality dialysis regardless of the ethnicity or the insurance of the patient. Mr. Chairman, when I call Fresenius to admit patients to their units, I don't have to worry that the patient will be declined because they don't carry insurance or they have Medicaid or there are other financial barriers, and this is unlike some of the other dialysis centers, like Sun Health, which --

MR. MORADO: Thirty seconds.

MR. SHAFI: -- Dr. Chawla mentioned. Rather, when I call his facility, those patients are declined because they have Medicaid insurance. I have seen Dr. Chawla do this for the last several years, because every time -- this is my personal experience. If I call him for my patient, first thing they have to go through is a vigorous financial screening. If they have Medicaid, they're declined. If they have Medicaid without supplemental insurance, they are declined. If they have no insurance, they would not be accepted in his unit.

So, I am really very happy the Board has finally realized that beside the over utilization, over capacity, the Board also should consider which dialysis center can accept which insurance, because some of these

dialysis centers, they don't accept Medicaid patients. And I'm here to defend and present my patients also.

Thank you very much.

VICE-CHAIRMAN HAYES: Now, if I could call to the Board's consideration Project 12-047, Fresenius Medical Care North Plainfield, and if the applicants would come to the table, and if the applicant who would specifically say their name, spell their name for the Court reporter, and then also be able to -- we'll have a swearing in of everyone at once.

MR. ALAUSA: Tunji Alausa (spells name).

MS. MULDOON: Coleen Muldoon (spells name).

MS. RANALLI: Clare Ranalli (spells name).

MS. WRIGHT: Lori Wright (spells name).

MS. GURCHIEK: Teri Gurchiek (spells name).

(Oath given)

VICE-CHAIRMAN HAYES: Mr. Constantino, can you give a State report?

MR. CONSTANTINO: Thank you, Mr. Chairman.

The applicants are proposing the establishment of a 12-station facility in approximately 8,500 gross square feet of leased space in Plainfield. The cost of the project is approximately $4.1 million.

I would like to make one short comment. We

can't accept written comments here at the public meeting, and we had one submitted here just for this project. We can't accept that. We can accept public comment, but not written comment.

MR. URSO: Oral comment, you mean?

MR. CONSTANTINO: Yes.

VICE-CHAIRMAN HAYES: So, basically you can accept oral comments, but any written comments, they would have to come to the public hearing or the public part of our meeting and be able to read that into the record? That's what you're saying?

MR. CONSTANTINO: We have time frames of when written comments can be submitted, and this is past the time frame here.

VICE-CHAIRMAN HAYES: Okay. So noted.

MR. CONSTANTINO: Thank you.

VICE-CHAIRMAN HAYES: Would the applicant like to give a presentation?

MS. MULDOON: Yes. We'll try to make this quick.

My name, as stated, is Coleen Muldoon. I'm the Regional Vice-President covering the Plainfield, Bolingbrook, Joliet, and Naperville area. This includes the current Fresenius Plainfield facility, which is located

so far south of Plainfield proper, where our proposed Plainfield facility will be located within an area that it is actually within a rock's throw of Joliet. It has a Plainfield mailing address, thus its name.

Essentially, Plainfield does not have its own dialysis facility, even though it is listed as one of the fastest growing cities in the United States between 2000 and 2010, as mentioned. We saw the need in the Plainfield area years ago, when patients from this growing community had to drive outside of Plainfield for treatment. In order to lessen the travel time hardships for these patients, we filed an application to establish the current Plainfield facility three times at three different locations over a period of six years. In 2008, the Board approved our project, and we opened in January 2010. In one year, we were at over 80 percent target, and we added four stations to this facility, and now we're currently -- in less than one year, we're at 84 percent utilization.

There is still a significant need for additional stations in Plainfield. I have observed Bolingbrook, Joliet, Naperville struggling with high-utilized facilities, because these areas have experienced the same high population growth as Plainfield. New facilities have been approved to create additional

access into each of these areas for those patients who reside there, not for the residents of Plainfield.

I also note that in a particular Service Area -- albeit within 30 minutes -- there are many choices of providers, including privately-owned entities like Fox Valley and Sun Health and DaVita, U.S. Renal and Fresenius facilities.

I would now like to introduce Dr. Alausa, who will be the Medical Director for the Plainfield North facility. After many years of working with him and his partners, I can assure you that when he says he has patients to refer to the facility in the next two years, he does. He has already proven that with the current Plainfield facility. And thank you for your time.

MR. ALAUSA: Thank you, Mr. Chairman and the Board, for giving me the opportunity to speak to you this afternoon. I am mostly here on behalf of my patients. These are very, very sick patients, dialysis patients. They have multiple medical problems. These patients, after dialysis, they are tired, they are worn out, they just want to go home and rest. A lot of these patients are African Americans, Hispanic, and most of -- quite a few, a significant amount of these patients as well do -- are not insured. They have Medicaid. Most of our patients have

Medicaid. So, I am especially asking the Board to please approve this facility for the sake of our patients.

I know that it's been mentioned about choice, and I'll quickly go to this. There are five different facilities in this area -- Fox Valley, DaVita, Fresenius, U.S. Renal and Sun Health. The one important thing that I want to bring to your attention is traveling distance.

This is the proposed clinic (indicating). If you look here, Fox Valley is over above 80 percent, which is above the State criteria. Montgomery is at 65 percent. It's listed at 29 minutes travel distance. This is not so, especially when you go to the Plainfield area. There's a bad traffic. There is so much travel now. I have a colleague that drives from Montgomery to Plainfield every day. It takes about 45 minutes to get to work. So that is -- if you look at Yorkville, that's 33 percent, but that's even further away from Montgomery. Now, the Fresenius Naperbrook is zero percent, but this is going to take patients from the current clinic. That clinic is going to close in the next few months. The hospital needs the space, so those patients are going to come here. So immediately this will be at 90 percent.

Bolingbrook is at 84 percent. This is our proposed facility. Within a year, we were at almost 80

percent. We came to the Board to ask for four more stations. Within six months of the Board approving the addition of four stations, our occupancy went to almost 84 percent.

The only clinic here is Sun Health, which is at 54 percent. This has been at this 54 percent for several years. The main reason is because the quality of this facility and they do not take Medicaid patient. He doesn't take uninsured patients and he doesn't take patients who even have Medicare but do not have secondary insurance.

So, if you look at the mix, we have about 30 percent of such patients. So, I ask you to please approve this clinic. It's -- I know the Board does everything to improve the -- according to the patients. One of the things that is needed is easier access to transportation for these patients. These patients are very sick. Please, for the sake of our patients, please, I especially ask you to approve this project. Thank you.

MS. RANALLI: I would like to very briefly comment on one thing that Dr. Alausa was speaking to, to wrap that up, which is Table One, which addresses the Board's criteria pertaining to mal-distribution in the area. Table One reflects 10 facilities, and the State

Board report said that 6 of the facilities were under utilized, and that is true, based upon the information that Mr. Constantino and his Staff had available to him. So, I'm not challenging that. But I did want to make it very clear that the Fresenius Plainfield facility, which is actually in Joliet, is not at 74 percent. It is currently at 84 percent, even slightly higher. That number is based upon an old number, because the Renal Network data is no longer available.

The other facility, Fresenius Naperbrook, is at zero percent, because it's not yet open. Again, that will be -- that's actually a relocation. So, when Naperville closes, that facility will automatically receive all the current Naperville patients and go to 90 percent.

The Oswego and Yorkville facilities are 27 and 29 minutes, respectively, from the proposed location. So, what you really have is three clinics that are under utilized, based upon your criteria -- one of them not open and one 27 minutes away and the other 29 minutes away. And the Sun Health facility, as mentioned, as Dr. Alausa said, for a few years has been at that 54 percent. I mean, I can remember 10 years back. It's always been around 55 percent, and there's nothing wrong with that, but that's where it is for the reasons that Dr. Alausa said.

I also want to point out that Fresenius, as a condition of being privileged at its facilities -- in other words, for a doctor to be able to admit patients there, it requires the doctor to accept Medicaid. That is a condition to be privileged and admit patients to Fresenius clinics.

VICE-CHAIRMAN HAYES: Thank you.

Could I have a couple of housekeeping before -- and then I'll open it up for Board comments. For the Staff here, we received in the e-mail, a letter from Bhuvan Chawla?

MR. CONSTANTINO: That's correct.

VICE-CHAIRMAN HAYES: September 3rd?

MR. CONSTANTINO: Right.

VICE-CHAIRMAN HAYES: Do we need a motion to put that into the record?

MR. CONSTANTINO: We do. It was responsive to the State Agency Report, and we do need to have a motion to include it in the record.

VICE-CHAIRMAN HAYES: Okay. And I'd like to do that now. I'd like to have a motion to put into the record a letter that was received on September 3rd of 2012 from Bhuvan Chawla. Could I have roll call, please?

MR. URSO: Can I ask one question? So this is

a response to the SAR then, Michael?

MR. CONSTANTINO: That's correct.

VICE-CHAIRMAN HAYES: Roll call.

MR. SEWELL: So moved.

MS. OLSON: Second.

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

Dr. Burden?

MR. BURDEN: Yes.

MR. ROATE: Senator Demuzio?

MS. DEMUZIO: Yes.

MR. ROATE: Mr. Eaker?

MR. EAKER: Yes.

MR. ROATE: Justice Greiman?

MR. GREIMAN: Yes.

MR. ROATE: Ms. Olson?

MS. OLSON: Yes.

MR. ROATE: Mr. Penn?

MR. PENN: Yes.

MR. ROATE: Mr. Sewell?

MR. SEWELL: Yes.

MR. ROATE: Chairman Hayes?

VICE-CHAIRMAN HAYES: Yes.

MR. ROATE: That's eight votes in the

affirmative.

VICE-CHAIRMAN HAYES: The motion passes. Now, I'd like to open up for Board member questions to the applicant.

Justice Greiman?

MR. GREIMAN: Same question. You'll accept the same condition as previously adopted by you?

MS. RANALLI: Yes, and all of our applications do state that we accept all patients, regardless of their ability to pay, and, as I mentioned, not only do we accept that condition, but it's a part of our privileging process for our clinics.

MR. GREIMAN: Thank you.

VICE-CHAIRMAN HAYES: Mr. Sewell?

MR. SEWELL: This is for my own education. Why are there just Medicaid-only patients for ESRD? Why aren't they dual eligible for Medicare also, because they're covered for Medicare, regardless of age.

MR. ALAUSA: No, not at all. You have to have worked and contributed into the Social Security before you can qualify for Medicare. If you haven't worked in your life, you will not be eligible to have Medicare.

MR. SEWELL: So, I didn't know that.

MR. ALAUSA: That's why quite a number of

these patients are Medicaid.

MR. SEWELL: That's good, for continuing education credits.

MS. RANALLI: And, also, undocumented residents for Illinois don't qualify for Medicare, but they do qualify for Medicaid.

VICE-CHAIRMAN HAYES: Can I recognize Dr. Burden?

MR. BURDEN: Thank you. I attended the public meeting that was held regarding this application, and I want to ask Michael Constantino. Is there an application from Total Renal Network on board in an ensuing meeting for this particular Plainfield area? I thought I heard that when I was at the public meeting here within the past several weeks. Am I wrong or right?

MR. CONSTANTINO: Not that I'm aware of, no. Courtney, do you know?

MS. AVERY: U.S. Renal.

MR. BURDEN: Well, I was at the meeting. The gentlemen here at the Board were at the meeting I was at. I listened to it, and I listened to a discussion regarding the private entity, U.S. Renal Network, surfaced, and I got the impression they were also interested in this area, which makes it a little interesting in terms of this

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application. If they're not, then --

MR. CONSTANTINO: Ms. Avery corrected me.

MR. BURDEN: That's remarkable. You're our bible over there.

MR. CONSTANTINO: There is an application.

MR. BURDEN: That brings up the all-together confusing rule that I have problems with when there's a competing unit, whether it's a hospital, radiation equipment, radiological service, or end stage renal. We as Board members are not allowed to consider applications that are in conflict or at least dual in the same area. Am I correct on that too, Michael?

MR. CONSTANTINO: You're correct.

MR. BURDEN: I have one more question I want to raise. Dr. Chawla sent a letter. Is this letter available for us to hear, or is it something that we should act to defer this application until we get an opportunity to read the letter that we just voted and approved?

MR. CONSTANTINO: We e-mailed that to you.

MR. BURDEN: I don't have it. Maybe my e-mail -- does everybody else on the Board have this?

(Pause)

MR. PENN: I just checked my e-mail, Mike. I don't believe I have it either. When was it sent?

MR. BURDEN: I submit I didn't get this. Now that doesn't make me have to recuse myself. I'm not about to read this at the last minute, but I'm going to comment about Dr. Chawla. Some accusations were made regarding his policies at his clinic, namely -- and I can't comment unless he would wish to comment -- that he does not accept Medicaid. That was made by one of the nephrologists with Fresenius. Is this covered in this letter, the issue about him accepting Medicaid that the Judge has raised? I'm asking the question. I don't know. I haven't seen the letter until now.

MR. CONSTANTINO: Dr. Burden, all he did was comment on the State Agency Report in that letter. That's all he was allowed to do. There was no mention of whether or not he took Medicaid or Medicare, no mention of his practice.

MR. BURDEN: For me, it influences my feeling on this application, if the good doctor who sits in our room now does not take Medicaid or Medicare. I think I heard both comments made by Dr. Mohammad -- whatever your last name is. That's a pretty strong statement. Does Dr. Chawla care to respond to that, or does he accept that as fact?

MR. ALAUSA: Yes, and I made the -- can I

talk?

MR. BURDEN: Of course.

MR. ALAUSA: I made the statement. I didn't mention Dr. Chawla by name. He owns Sun Health. He does not accept my Medicaid patients. He does not accept my patients with Medicare, and he does not accept uninsured patients.

VICE-CHAIRMAN HAYES: And this is an issue. Mike, did you have -- normally you bring hard copies to our meetings of these letters and distribute them to the Board members.

MR. CONSTANTINO: Yes, I've got hard copies, yes. If you would like I can distribute it, yes.

VICE-CHAIRMAN HAYES: Would Dr. Burden and Member Penn be interested in that?

MR. PENN: Yes.

VICE-CHAIRMAN HAYES: Okay. Can you distribute that?

(Pause)

VICE-CHAIRMAN HAYES: Now, basically, I would comment. Obviously, we have a public comment period, and we have a public comment in our meetings as well, and we don't want to open that up here. Now, what we -- if there is -- if the Board members feel they can have an Intent to

Deny and vote no on this motion and, thus, we'd be able then to take into consideration these -- Dr. Chawla's comments and other things that maybe the Board members feel would need to be addressed. So, that is an option that is available.

MS. RANALLI: I would like to say, we don't -- we would defer. We don't want to vote an Intent to Deny. We would defer, if that's an issue for you. However, I would point out that to my knowledge, I don't know that we can require Sun Health to make a statement affirmatively one way or another about its policies. What we do have on the record here is two physicians saying that they do not accept their referrals of Medicaid patients or Medicare patients that don't have supplemental. That information is in front of this Board today, and we also have the fact that utilization is at 54 percent and evidence or testimony before you that it has consistently been at that level, and for years and years, and it was at that level when the Plainfield -- the current Fresenius Plainfield clinic was approved. If the board had not approved the current Plainfield clinic because Sun Health facility was at 54 percent, then all the patients that are currently going there -- that 80 percent utilization within one year -- would have had to travel much longer distances. So, Sun

Health is simply an outlier. I don't believe that, based upon history, it should be relied upon to deny access to care, whether it be Fresenius or any other applicant in front of you.

And the U.S. Renal application, the public hearing that Dr. Burden was referencing was not on our application, not on the Fresenius application. It was on the U.S. Renal application, which is why you recall that circumstance, and they called the hearing on themselves.

MS. MULDOON: I just want to point out one other thing on this map. You have to pass two facilities that are over 80 percent utilized to get to the Sun Health facility and to get to our new facility. So there's two units in between there that are over 80 percent utilization.

MR. BURDEN: I believe my feeling has been expressed.

MR. SEWELL: I would defer to Mr. Urso on this, but I don't think our instructions should be limited to the option of Intent to Deny when, as the applicant suggested, they prefer a deferral. That's also an option. So that's one thing. The other thing is that this letter -- we appear to be giving more weight to someone who testified at a public hearing than we normally do. This

physician has sent a letter and has shown up to give oral testimony and now it's as if we want to take what he has sent into consideration during the period where we are considering the application. I guess I worry about that procedurally. But I would defer to Mr. Urso on that.

MR. URSO: According to our records, Mr. Sewell and other Board members, this applicant has an opportunity to defer, if they so choose. That's what I see in our documentation. So they can defer. That is correct.

Your second question had to do with comments on the State Agency Report. According to the Board's statute, when you receive those kinds of comments, you should be reviewing those and making a determination. Do you want to go forward with this particular application? Do these requirements require further analysis? Or are you going to reject these comments as they're not responsive to the State Agency Report? So there are several options you can fall back on.

MR. SEWELL: So it doesn't matter that the same person that submitted this also had oral testimony?

MR. URSO: You mean, public participation today?

MR. SEWELL: Yeah.

MR. URSO: There's nothing that would prohibit

that.

MR. SEWELL: And it also doesn't matter that this letter doesn't speak to the issue that Board members are concerned about? Board members are concerned about this allegation that this -- not the applicant. This competitor does not take Medicaid, does not take Medicare, unless they have supplemental insurance and all of that. I don't think this letter speaks to that.

MR. URSO: First of all, you need to decide if you're going to accept that letter, and I think you've already done that. So, you're saying, "We accept this letter as being responsive to the State Agency Report," and now you're considering this project, and the applicant, the way I understand it, is making some assertions here that other providers in the area may not have an open enrollment, so to speak, clinic or accept all patients. I think if the Board wanted to accept their deferral, the Board then could say, "Okay, Applicants, you made the statement; you need to verify that. You need to show us that, in fact, this is correct information."

MS. AVERY: I want George to read the profile for Sun Health. George.

MR. ROATE: Thank you. Information taken from the 2011 ESRD Profile shows Sun health in Joliet had a

total of 69 Medicare patients to comprise 88.5 percent of the patient load, 2 Medicaid patients to comprise 2.6 percent of the patient load, 6 private insurance patients to comprise 7.7 percent, and 1 patient to comprise 1.3 percent of the patient load.

Thank you.

VICE-CHAIRMAN HAYES: Mr. Carvalho?

MR. CARVALHO: Yes. To put that in context, what I've also pulled up are percentages at Sun Health. The percentage of Medicaid is 2.6 percent. For the State as a whole, because we've compiled these data for the State as a whole, the percentage of Medicaid at end-stage renal dialysis centers is 11.6 percent. So, based on the information we have, the Medicaid percentage of patients at Sun Health is 2.6; State average, 11.6 Those are the data that we have for 2011.

MR. BURDEN: Thank you.

VICE-CHAIRMAN HAYES: Do we have any comments on the --

MR. BURDEN: Well, I made my position prior to Mrs. -- excuse me -- Attorney Ranalli's lecture regarding my misinformation. I didn't think I was that far off. So Dr. Chawla's under-utilized facility does accept Medicaid and does accept Medicare, albeit significantly less than

the applicant. That does not fit -- does fit with what my observation was, and we ought to know that data. I still feel that the opportunity to defer should be included in the options for them to consider, since I've brought up this possibility, and apparently I'm right, that there's another unit, another dialysis unit that's looking to consider Plainfield as a location. I don't know how we can consider all of this data we have today without knowing all the facts. I mean, I for one feel that's what should be considered. That's up to them and the rest of the Board members.

MS. RANALLI: If I may --

VICE-CHAIRMAN HAYES: I understand that Dr. Chawla does not want a third shift, and let's talk to the applicant then, because you have the option to defer, as well.

MS. RANALLI: Well, yes, we could defer. I referenced deferral in the context of the reference to an Intent to Deny and, of course, it's up to the Board, if the Board feels that it needs additional information before it. I think that what we heard regarding the percentage of Medicaid at the Sun Health clinic is helpful, and illustrative, as far as the issue that Dr. Alausa and Dr. Shafi raised, and I'm looking -- in our application, we

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submit to you at page 41 and 42 all of our clinics and the percentage of Medicaid that we provide at those clinics, because we feel that's useful information to you. You can see what geographic areas have different Medicaid levels and which don't, and when you go down our list -- 10 percent, 26 percent, 16 percent, 11 percent, 30 percent, 13 percent, 45 percent, 45 percent. I'm just starting. So, I mean, that gives you a pretty good indication that what Dr. Alausa and what Dr. Shafi told you about that clinic is a reality. But the only issue that really goes to is its utilization level, because you're looking at mal-distribution, and you want to assure yourselves, if you approve this application, that you're not contributing to mal-distribution in the area, and that's why I talked about Table One, which has the clinics in the area. That shows that there's really only a couple of clinics that have -- that are below your 80 percent target, other than Sun Health, which would be per the reason why it does not, and that it also operates two shifts. And those clinics are 28 and 29 minutes away from the proposed site, and we've heard significant testimony about the growth in the area and the challenged population and the traffic congestion in the area. So, that's why we're talking about Sun Health's Medicaid utilization, in my mind. I mean, if there is

other concerns, that's not necessarily for this application. That has to do with a different point.

Thank you. I'm sorry. I didn't mean to talk too much.

VICE-CHAIRMAN HAYES: Well, I'd like to --

DR. ALAUSA: Thank you, Mr. Chairman. I think we've provided the facts here today that are specific, and I know the Board does everything to enhance access to care. That's the business of this application, and the fact that we have a lot of uninsured population, Medicare population, and Fresenius has been known to take care of these patients for us. Fresenius quality indicators are very good. So, I think we provided a lot of facts that the Board needs to make a decision today.

MR. PENN: I just have a quick question.

VICE-CHAIRMAN HAYES: Member Penn?

MR. PENN: How many actual stations does Fresenius own in the state of Illinois? How many different locations? Do you know?

MS. RANALLI: How many --

MR. PENN: -- stations do you actually own in how many locations? You have 5 of the 10 in this 30-minute driving radius. You'll soon have or ask to have 6 of the 11. I'm just curious, how many do you actually own in the

state of Illinois?

MS. RANALLI: The total amount of clinics, I think, throughout the state is around 100.

MR. PENN: How many stations?

MR. ALAUSA: I know the Board also puts a lot of emphasis on choice. There is enough in that market area. There are five providers. One thing about our patients is that we are probably the busiest group in the area. When we work with Fresenius we know we have quality of care and access to care. We work closely and that's why.

MR. PENN: The answer is, you have over 100 facilities in the state of Illinois?

MS. MULDOON: Yes, we probably have over 100, but to understand that, with each of those facilities we're working with different practices, different nephrology groups. So, if you turn one of our facilities down, that's a practice that has come to us, wanting to work with us, that you're turning down. I know you've done this in the past. We're looking at new business coming in or giving patients an option, but with each one of our facilities, it's different physician practices that we're working with. They come to us because Fresenius has a reputation, and it's a strong reputation in the community and around the

United States, as does DaVita. We have many facilities, but we're committed to dialysis. That's the business we're in. We're not getting out of that business. We'll always be in that business, and the physicians know that that come to us as practicing and wanting to work with us, and they're coming here because we are Fresenius, and they know that we provide excellent care.

MS. RANALLI: And in this area, Mr. Penn, there are numerous choices. I mean, there are times when Fresenius is the predominant provider, but we have independent providers, DaVita, U.S. Renal, Fox Valley. So, there are a number of different choices in this particular area, if that's of concern.

MR. PENN: There's only three that's boxed in between Fresenius in Plainfield and Bolingbrook. There's only three, and that appears to be your targeted market, the three that are closest to Plainfield.

MS. RANALLI: Well, the closest to the current Plainfield clinic, there's Silver Cross West, which is Davita, U.S. Renal, Fox Valley, an independent. Two Fresenius --

MR. PENN: This new location, would it be closer between Silver Cross and Fox Valley? You want to fit yourself in between those two locations?

MS. RANALLI: Right. And that's DaVita and Independent, so --

VICE-CHAIRMAN HAYES: Mr. Carvalho.

MR. CARVALHO: Just a quick question. It seems to come up a lot, this issue of distance of travel for the patients. One of the patients mentioned how tiring it is to travel long distances and made me wonder. Is the standard of care that the patient transports themself? I know I've had medical procedures; I'm told someone else needs to drive you, you're not supposed to drive yourself. Is that what we are basing our model on, that the patients transport themselves, in which case that issue is an important one, or are we expecting them not to transport themselves?

MR. ALAUSA: Yes, when we have a choice, but a lot of them are limited, based on their insurance. They have to transport themselves. The Disability and Medicaid will only cover some category of patient. So, a significant number of patients -- almost 80 percent -- will have to transport themselves, because they don't have State support to transport themself.

MS. MULDOON: A lot of the families transport them, but if they do go to public transportation, they may sit and wait an hour after dialysis, because they also pick

up three patients, not just one patient. So they'll wait for everyone to come off dialysis and then they transport the patient. So patients then, or even a family member, is going to sit there four hours or go back home and come back to pick up the patient. But many of our patients don't drive themselves. They are too weak to drive after dialysis.

VICE-CHAIRMAN HAYES: What I'd like to propose is that we have a motion to defer this project. Now, this -- you have the right -- the applicant has the right to defer it on their own. Now, the information -- we may well reject that motion to defer the project, but I think we've heard enough from some of the members that that is a motion that should be considered by the Board. Does the applicant have any problem with that?

MS. RANALLI: No, if that's the Board's preference, to poll the members to determine whether it may be helpful on your part with regard to your decision making to defer. That's acceptable to us.

VICE-CHAIRMAN HAYES: In the motion to defer, there has been -- some members have expressed that there has been information that has not been provided to the Board, specifically different comments that have been made on the State Agency Report, and thus -- and in this motion,

it is imperative that a yes vote will be for the motion to defer this project and, thus, the Board members that vote yes, it would be imperative for them to be able to explain what additional information that they would need to make this decision. You know, what do they want the applicant to provide that would allow them to be able to go ahead with this application and vote on it? Is there any comments from the Board?

(Pause)

VICE-CHAIRMAN HAYES: Can I have a motion on -- to defer Project 12-047, Fresenius Medical Care, Plainfield North, Plainfield? Can I have a motion for that.

MR. GREIMAN: So moved.

MR. PENN: Second.

MR. ROATE: Motion made by Justice Greiman, seconded by David Penn.

VICE-CHAIRMAN HAYES: Before this, a yes vote would be for deferral, and a no vote will be against deferral, and we'll go ahead and go to the vote on this project.

MR. ROATE: Dr. Burden?

MR. BURDEN: I vote yes to defer, the reasons being, there's a significant amount of -- in my mind, for

one, we've had letters that may or may not affect my eventual vote that I haven't seen that were presented here to me within the past several minutes. Number two, I did mention about U.S. Renal Care. I want to have a clear understanding. I did hear they do have a unit here which hasn't opened. There were accusations made at a prior meeting that there were some reasons why it hasn't opened. I'd like to know more about it, since it is in the area, the catchment area we're talking about. Number three, I really am confused about some of the data that's been presented that does not necessarily complement the Table One data that I have in front of me. So, I would feel deferral would allow an opportunity to clear up all of the ambiguities so that I would be comfortable with going forward and defend a vote. That's my reason for saying yes.

MR. ROATE: Senator Demuzio?

MS. DEMUZIO: No.

MR. ROATE: Mr. Eaker?

MR. EAKER: No.

MR. ROATE: Justice Greiman.

MR. GREIMAN: Yes.

MR. ROATE: Ms. Olson?

MS. OLSON: No.

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MR. ROATE: Mr. Penn?

MR. PENN: Yes.

MR. ROATE: Mr. Sewell?

MR. SEWELL: No.

MR. ROATE: Chairman Hayes?

VICE-CHAIRMAN HAYES: I'm going to vote for this amendment, because of the reasons that were described and the information that would be needed. So I'm going to vote for this motion.

MR. ROATE: I have four votes for and four votes against.

VICE-CHAIRMAN HAYES: The motion fails, and let's continue on. The motion has failed for deferral, and now we will -- any more questions from the Board?

(Pause)

VICE-CHAIRMAN HAYES: Okay. I would like to then go into a motion to approve Project -- may I have a motion to approve Project 12-047 to authorize the establishment of a 12-station ESRD station in Plainfield, Illinois?

MR. PENN: They have the right to ask for deferral.

VICE-CHAIRMAN HAYES: That's correct. Now, I believe -- why don't we give them an opportunity to do

that, even though twice I've asked them already.

MS. RANALLI: I appreciate that. Thank you. We will go with the vote. Thank you, and thank you for all of the time that everyone has spent. We appreciate it.

VICE-CHAIRMAN HAYES: Okay. Thank you. Now, I'll go with this motion. May I have a motion to approve Project 12-047 to authorize the establishment of a 12-station ESRD facility in Plainfield, Illinois, and the applicant will treat all patients, no matter of their ability to pay, and that they will notify their doctors that they will also treat all their patients, no matter their ability to pay. Can I have a motion to that effect?

MS. OLSON: So moved.

MR. EAKER: Second.

MR. ROATE: Motion made by Ms. Olson, seconded by Mr. Eaker.

VICE-CHAIRMAN HAYES: Roll call.

MR. ROATE: Dr. Burden?

MR. BURDEN: I continue to vote no. There's a calculated excess of 47 stations. Following the State Board standards, this calculated excess is the primary reason for me saying no.

MR. ROATE: Thank you. Senator Demuzio?

MS. DEMUZIO: No, and I agree with Dr. Burden.

MR. ROATE: Mr. Eaker?

MR. EAKER: I vote yes.

MR. ROATE: Justice Greiman?

MR. GREIMAN: Yes.

MR. ROATE: Ms. Olson?

MS. OLSON: No.

MR. ROATE: Mr. Penn?

MR. PENN: I vote no because of excess capacity.

MR. ROATE: Mr. Sewell?

MR. SEWELL: No. Excess capacity.

MR. ROATE: Chairman Hayes?

VICE-CHAIRMAN HAYES: I vote no because of the Planning Area need and the excess of 47 stations in this area and also because of mal-distribution or unnecessary duplication of services, because of the other facilities in the area that do not meet the State standards.

MR. ROATE: That's six votes in the negative, two votes in the affirmative.

MS. RANALLI: Thank you, and, again, thank you for your time.

MR. URSO: So, you'll be receiving an Intent to Deny. You'll have an opportunity to come before the Board, as well as submit additional information.

MR. CONSTANTINO: Mr. Chairman, our Court Reporter would like to take a quick break.

VICE-CHAIRMAN HAYES: Yes, I imagine. It's 3:30, and if we could have a 10-minute break and come back on time, so we can get moving on this as well. Thank you very much.

(Recess)

VICE-CHAIRMAN HAYES: I'd like to call us to order.

Now, we're changing the order of the agenda here, and first we're going to Applications Subsequent to Intent to Deny, and we're going to look at I-02, DaVita Lawndale Dialysis, Chicago. I understand there is some public comment on that, and if they could come forward, and we'll start there and get this moving. So, please, public comment on DaVita Lawndale Dialysis, Chicago.

(Pause)

VICE-CHAIRMAN HAYES: This is 11-103, DaVita Lawndale. David Frankel, John Kniery, Marcie Hefler, Cara Goldsberry, and Mohammed S. Shaw (phonetic). And if you could spell your name and give your name to the Court Reporter, and then also mention if you're in support or opposition to this project. So, David Frankel.

MR. FRANKEL: Yes. My name is David Frankel

(spells last name). I'm here in support.

Good afternoon, Mr. Chairman and Members of the Board. My name is David Frankel. I serve as the Vice-President of Planning, Marketing and Communications for Sinai Health System, the not-for-profit parent organization of Mount Sinai Hospital and Schwab Rehabilitation Hospital. Sinai is located in the center of the North and South Lawndale communities, on the west side of Chicago.

I am here today to express Sinai's full and enthusiastic support for the Lawndale Dialysis application, the joint venture between DaVita, Zoa Associates, and Mount Sinai Hospital, to establish a new 16-station dialysis center in the South Lawndale community, which would be located 2.2 miles from the hospital.

Sinai had previously expressed opposition to this project for two reasons. First, we believed that in the original project CON application, DaVita representatives did not fully satisfy the letter or the intent of Section 5.4 of the Illinois Health Facilities Planning Act, which requires applications for substantive projects to include a Safety Net Impact Statement. As a 22 percent joint venture partner in the updated project structure, Sinai will now be in a good position to help

assure, with our partners, that all patients seeking dialysis care at the new center will receive services regardless of their insurance coverage or ability to pay.

Also, to the extent that this proposed joint venture generates a positive margin in the years ahead, Mount Sinai Hospital's share the net income would help cross-subsidize our safety net services, such as Level I trauma care for adults and children.

Sinai's second reason for our prior opposition was some concern about the level of utilization of current dialysis centers within 30 minutes travel time and future demand for additional dialysis stations in our community.

MR. MORADO: Thirty seconds.

MR. FRANKEL: After extensive conversations and review of market data with the DaVita team, we now believe that the high and increasing rates of diabetes and hypertension in South Lawndale and neighboring areas will, unfortunately, increase the need for outpatient dialysis services during the next five years and beyond our prior projections. In short, the reasons that motivated our prior concerns about this project have been fully addressed. We have established an excellent collaborative relationship with the DaVita team.

On behalf of Mount Sinai Hospital, I

respectfully request that you vote to approve the CON application for Project 11-103 for our joint venture with DaVita and to open a new 16-station dialysis center in South Lawndale.

Thank you.

VICE-CHAIRMAN HAYES: Thank you, Mr. Frankel. The next speaker is -- for the record, Mr. David Carvalho, he is accused (sic) from this public comment period, as well as discussion on this applicant. I believe Mr. Carvalho has left the room.

Now if we could hear from John Kniery.

MR. KNIERY: Thank you, Mr. Chairman. I'd like to read in this letter, since we can't submit any written comments.

Dear Mr. Galassie: Please accept the letter from St. Anthony's Hospital in opposition to DaVita Lawndale project. With Mount Sinai Hospital joining forces with DaVita, this under served community remains at risk. St. Anthony's Hospital has found that there is a need to be better control in the level of care that ESRD patients are receiving, including monitoring of health conditions that are prevalent with such patients, as well as enduring regular treatment -- ensuring regular treatments. Such care must involve the whole patient and educating family

members on maintaining and preventing diseases. Another for-profit ESRD center as being proposed, regardless of who has ownership, does not alleviate the kinds of issues described herein.

St. Anthony's seeks to reiterate the concerns Mount Sinai Hospital offered against the project. Mount Sinai stated the issue because of the project's impact on safety net providers. Even with the union of the hospital applicant, a free-standing ESRD center is not the best delivery method for care and education.

Second, Mount Sinai stated that DaVita's CON failed to provide a Safety Net Provider Impact Statement that is reasonably comprehensive in its content and in its conclusions.

Three, just because this proposed project has a hospital as a minority shareholder does not change the potential for (unintelligible) safety neat providers. St. Anthony's Hospital is not a large tertiary, Level 1 trauma center. Rather, it's a small hospital with an outreach that is entrenched in the community it serves. The area needs comprehensive (inaudible) where overall health and well-being can be provided simultaneously without cause for additional disruption to work and family schedules. St. Anthony Hospital would sincerely appreciate

the opportunity to partner --

MR. MORADO: Thirty seconds.

MR. KNIERY: -- with you at your proposed retreat specifically to discuss dialysis and its delivery system.

Thank you for your consideration of this matter. Sincerely, Guy A. Medaglia, President and Chief Executive Officer of St. Anthony Hospital.

VICE-CHAIRMAN HAYES: Thank you, Mr. Kniery.

Our next speaker would be Marcie Hefler.

MS. HEFLER: Good afternoon, Mr. Chairman and Members of the Board. My name is Marcie Hefler. Earlier this year, Mount Sinai appeared before this Board in its opposition to the CON application for Permit 11-103. In its opposition, Mount Sinai argued that DaVita's application did not provide comprehensive or accurate information and/or conclusions as it relates to the Safety Net Providers Impact Statement. As a (unintelligible), our community, Mount Sinai, are passionately and staunchly against DaVita's application, detailing the extensive and adverse negative financial impact that the for-profit dialysis center would have upon Mount Sinai and its ability to provide for charity care.

Mount Sinai, as a not-for-profit safety net

hospital, told you that DaVita is a global for-profit corporation with $7 billion in revenue and $400 million profit in 2011 alone, and in its plea for you to deny this application, Sinai was concerned about the quality and ability to provide better community care. In July, Mount Sinai (unintelligible) of the community was silenced by a promise of 22 percent return in the profit. Mount Sinai did not gain a controlling interest in this new venture. Rather the concerns so eloquently proffered by Mount Sinai remain looming. Nothing has changed and DaVita still remains in control. The only thing that changed here, ladies and gentlemen, is Mount Sinai's withdrawal of its objection was brought out by this for-profit corporation for 22 percent.

The Safety Net Impact Statement remains unchanged by this troublesome union of DaVita and Mount Sinai. The impact to our community, the community of the uninsured, the under insured and the undocumented population, remains unchanged by this marriage of convenience. Mount Sinai's so-called concern about our community and the quality of care provided remains unaddressed and this population remains vulnerable and unprotected.

On behalf of the residents of the St. Anthony

Hospital community, we urge you to vote to deny the approval of DaVita's CON application for Permit 11-103.

VICE-CHAIRMAN HAYES: Thank you, Ms. Hefler.

Now I'd like to -- Cara Goldsberry.

MS. GOLDSBERRY: My name is Cara Goldsberry (spells name), Project Manager for St. Anthony Hospital.

Mr. Chairman and Members of the Board, thank you for this opportunity to be before you today. On behalf of St. Anthony Hospital, located directly in the Lawndale community, I oppose the proposed project. The challenges of serving the most vulnerable patients false on the safety net community hospitals, not the for-profit corporations. St. Anthony Hospital, like Mount Sinai, our neighbor down the street, has been providing care to the community for the last century. We have been the gatekeeper for the under insured and the underserved residents of the North Lawndale and South Lawndale communities in Chicago.

The mission of St. Anthony has been to provide quality care to those who need it most and turning no one away. As a comfort and presence in the community, both African American and Latino residents have been entering our doors for their healthcare, preventative education, and social service needs. The umbrella care that St. Anthony provides is directly straight from the voice of the

residents. We ask, how can we help? Listen to answers and tailor free programs for the residents.

As we continue to explore community health issues, we know the community is at high risk for obesity, hypertension, and diabetes, which often result in end-stage renal disease. As a safety net hospital, we continue to see a lack of continuity and consistency in education and caring for this population. The prevalence of these conditions reflects a need to address the whole person, which can't be accomplished in another outpatient dialysis facility.

The community will not benefit from another for-profit ESRD corporation entering this neighborhood. This disenfranchised population does not need more of the same. Really this population needs the (inaudible) in a clinic setting --

MR. MORADO: Thirty seconds.

MS. GOLDSBERRY: -- which is not being proposed in this project.

It is our understanding that the Board is interested in having an educational in-service on dialysis. St. Anthony would like to participate in those discussions.

Thank you.

VICE-CHAIRMAN HAYES: Thank you. Is Mohammed

S. Shaw (phonetic) here for public comment.

(No response)

VICE-CHAIRMAN HAYES: Okay. Thank you very much.

Now I'd like to call the applicants to the table.

(Pause)

VICE-CHAIRMAN HAYES: This I-02, DaVita Lawndale Dialysis, Chicago, and if you could say your name and spell it for the Court Reporter, and then she will do a collective swearing in.

MS. DAVIS: Penny Davis (spells name), DaVita.

MR. FRANKEL: David Frankel (spells name), Sinai Health System.

MS. FRIEDMAN: Kara Friedman, Polsinelli Shughart.

VICE-CHAIRMAN HAYES: Mike, the Staff report, please.

MR. CONSTANTINO: Thank you, Mr. Chairman.

The applicants are proposing to establish a 16-station ESRD facility in Chicago, Illinois. They had received an Intent to Deny, and subsequent to that Intent to Deny, they modified the project with a joint venture with Sinai Hospital. They're here today to tell you about

that and hope for your approval.

Thank you, Mr. Chairman.

VICE-CHAIRMAN HAYES: Thank you, Mr. Constantino.

Does the applicant want to say a few things to the Board?

MS. DAVIS: Yes, I'd love to. Thank you. First of all, thank you for allowing us to return, and special thanks to Board Staff who assisted us in this matter. DaVita is proposing to establish a 16-station facility in the City of Chicago, in the socioeconomic disadvantaged community of Lawndale. DaVita, as you know, is very concerned about the patient as a whole. You've heard me say this over and over again. Recently, we acquired a company called Healthcare Partners, who are more involved in primary care medicine and providing care holistically to patients, not just through dialysis. This project is a further commitment to patients in need.

Through our education and training programs which we offered to the Little Village facility in that community, we provide CKD education. Our goal is to prevent patients from having dialysis. Unfortunately, that's not always the case, and so CKD education gives them every opportunity, gives them every resource possible.

We are about transplant. We have one of the highest transplant rates in the country and, as a community, we understand that this community faces a number of disadvantages in terms of access to care. You heard at the last meeting, at the July meeting, Alderman Munios (phonetic), who talked about how this facility will benefit the Lawndale community. In addition, the neighborhood not-for-profit Federally Qualified Health Center, Lawndale Christian Health, has also gone on record in support of our proposal, recognizing the need for additional healthcare resources in this community. Lawndale Christian, too, cited the access disparities of the Lawndale community bases, particularly the higher rates of diabetes, lower income, lack of insurance and lack of education. We also have provided data from a recent Mount Sinai health survey, which found that the North and South Lawndale communities have the highest obesity rates in the City of Chicago.

Finally, as you have learned, we are now moving forward with this project as a joint venture with Dr. Ogbonnaya. You met him back in February, a young, excited, very compassionate nephrologist, who, having done his fellowship at the University of Chicago, chose to serve the West Side community. We have worked with both Mount Sinai Hospital and Dr. Ogbonnaya to better understand and

alleviate the safety net impact. The only time there's a safety net impact is if the provider, the safety net provider provides those same services. So, for St. Anthony's to talk about safety net, they don't currently provide dialysis services. So, we went to the facility, to our partner, now partner, Mount Sinai, who does provide dialysis and said, how can we do this better? How can we make sure that we take care of this community.

In the last year, there's been an increase in this very small community of 175 patients receiving treatment for end-stage renal disease. Dr. Ogbonnaya, who you met, the planned Medical Director for the facility, is treating 148 CKD patients right now, whose conditions is advancing to end-stage renal disease. Our Little Village facility is consistently operating at 100 percent utilization. As we have discussed with you before, Hispanics and African American community are at increased risk end-stage renal disease, due to the higher prevalence of diabetes and hypertension. As we've documented for you in the past, the Lawndale community is the predominantly African American and Hispanic population.

When it comes to healthcare services access limitations, the City of Chicago is unlike any other in the state of Illinois. On top of the difficult pyramids that

many providers turn away from, it is very difficult to find appropriate property to develop and is suitable for healthcare use. This is the challenge I face in almost every City of Chicago project that I've worked on. With this project, we have worked with Ogbonnaya as our Medical Director and gone back to the landlord and asked them to extend to this meeting.

The Board identifies inventory, that states a need for 82 dialysis stations in the City of Chicago. While your standards provide for a 30 minute Service Area, we believe that from an access perspective, you won't find a better placement for these stations in any other location in the City of Chicago.

Finally, I'd like to thank the development company who has worked with us and has held this property for us, knowing the need for healthcare access in the community.

I'd like to turn it over to David Frankel from Sinai, who is our new partner in this proposed project.

MR. FRANKEL: Thank You, Penny.

I think it's important to note that Sinai's extensive community-based healthcare capabilities and large employment uniquely positions us to offer patients to receive care in the proposed center, ready access to our

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complete continuum of high quality continuum of care and subspecialty services, regardless of each patient's ability to pay. I am, frankly, surprised that representatives at St. Anthony Hospital here today, having never expressed concern about this project before today. This project was filed in the fall, and our participation in this unit has been a matter of public record since July.

Before we appeared before this Board to weigh in last February, we sat down with DaVita to express our concerns. We're here today after a lot of hard work to come together to meet the needs of this tremendously under served community. I don't think it is fair to this Board or the Lawndale community for St. Anthony's to enter into this dialogue today. We are a safety net dialysis provider. St. Anthony is not in this community.

We employ several nephrologists and operate a 16 licensed stations ESRD unit at the hospital. We want to see this need met. We cannot do it currently without DaVita. St. Anthony is welcome to be a dialysis provider in its community, but not at the expense of this project.

VICE-CHAIRMAN HAYES: Okay. I'd like to -- is there anything else from the applicant?

(Pause)

VICE-CHAIRMAN HAYES: Okay. I'd like to open

up for questions from the Board.

(Pause)

VICE-CHAIRMAN HAYES: One question that I had is that -- would you be available -- would you accept the condition that I think you've accepted -- or at least your competitors have today? Would you be willing to accept that condition to this permit?

MS. DAVIS: Actually, it's part of our joint venture with Mount Sinai. We have that exact language within our Partnership Agreement, and that is that we accept all patients, regardless of ability to pay. The physicians in the community who would be referring to this center include Dr. Ogbonnaya, the nephrologists at Mount Sinai Hospital, all of whom know accept patients without -- regardless of ability to pay. The interesting -- one interesting thing is that Dr. Ogbonnaya is actually, I believe, the largest nephrologist practice at St. Anthony's Hospital, and he's chosen to do this project with Mount Sinai and DaVita.

VICE-CHAIRMAN HAYES: Thank you. Are there any other questions from Board members?

(Pause)

VICE-CHAIRMAN HAYES: Seeing none, I will -- may I have a motion to approve Project 11-103 to authorize

the establishment of a 16-station end-stage renal dialysis facility in Chicago, Illinois, and the applicant will treat all patients, regardless of their ability to pay, and the applicant will also notify all their doctors that they will treat all patients, regardless of their ability to pay. Can I have a motion?

MR. GREIMAN: So moved.

MR. PENN: Second.

MR. ROATE: Motion made by Justice Greiman, seconded by Mr. Penn.

VICE-CHAIRMAN HAYES: Roll call.

MR. ROATE: Dr. Burden?

MR. BURDEN: I voted positively for this application the last time. I'm even more strongly endorsing it now. I'm happy to hear Mount Sinai step forward. Dr. Ogbonnay is on staff with the Missionary Sisters who have a mission. I'm disappointed to hear the Missionary Sisters of St. Ann be negative about this. It bothers me, because I have had an association with them within my practice days. But I endorse this project. I vote yes.

MR. ROATE: Senator Demuzio?

MS. DEMUZIO: I'm going to vote no, due to the number of excess communities that feed into that area.

MR. ROATE: Mr. Eaker?

MR. EAKER: I've heard nothing that changes my vote from previous time regarding the mal-distribution of service. I vote no.

MR. ROATE: Thank you. Justice Greiman?

MR. GREIMAN: If you -- maybe if you're a downstater, you think about this in a different way. Lawndale is a community that can't have too much medical care there. It's a community of incredible poverty you don't see downstate in any community. It's a terrible place, has terrible problems. I voted no last time, and it bothered me after. I'm here to say that the merger of Mount Sinai with them makes it a whole different scene. They're doing good work there in that community. That's what I care for. I vote yes, and change my vote.

MR. ROATE: Ms. Olson?

MS. OLSON: I vote no, based on excess capacity.

MR. ROATE: Mr. Penn?

MR. PENN: With the merger of Mount Sinai, I am going to vote yes for this project.

MR. ROATE: Mr. Sewell?

MR. SEWELL: I vote no, Unnecessary duplication of services.

MR. ROATE: Chairman Hayes?

VICE-CHAIRMAN HAYES: I'm going to continue to vote yes for this project, because of the need for ESRD services in this community, and I think the partnership with Mount Sinai is something that will improve this project. So, I'm going to vote yes.

MR. ROATE: Thank you, sir. That's four votes in the negative and four votes in the affirmative.

VICE-CHAIRMAN HAYES: The motion fails, and Frank --

MR. URSO: You will receive a denial formally, from the denial. You'll have an opportunity for due process and having an administrative hearing, if you so desire. Thank you.

VICE-CHAIRMAN HAYES: Thank you very much.

MR. CONSTANTINO: Mr. Chairman, we have some housekeeping. We need to request a board deferral of that Tazwell County project, just for the record.

VICE-CHAIRMAN HAYES: I'd like to have a motion to defer Project 12-052, DaVita, Tazwell County Dialysis, Pekin.

MR. SEWELL: So moved.

MS. OLSON: Second.

MR. ROATE: Motion made by Mr. Sewell,

seconded by Ms. Olson.

VICE-CHAIRMAN HAYES: Excuse me. Before we vote, can I recognize Member Penn?

MR. PENN: Did the request come from the applicant?

MR. ROATE: Yes.

Okay. Motion made by Mr. Sewell, seconded by Ms. Olson.

Dr. Burden.

MR. BURDEN: Yes.

MR. ROATE: Senator Demuzio?

MS. DEMUZIO: Yes.

MR. ROATE: Mr. Eaker?

MR. EAKER: Yes.

MR. ROATE: Justice Greiman?

MR. GREIMAN: Yes.

MR. ROATE: Ms. Olson?

MS. OLSON: Yes.

MR. ROATE: Mr. Penn?

MR. PENN: Yes.

MR. ROATE: Mr. Sewell?

MR. SEWELL: Yes.

MR. ROATE: Chairman Hayes?

VICE-CHAIRMAN HAYES: Yes.

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MR. ROATE: That's eight votes in the affirmative.

VICE-CHAIRMAN HAYES: The motion passes.

I also want to make the Board aware that I-01, Fresenius Medical Care, Prairie Meadows, Libertyville has been deferred.

I'd like to have a motion for adjournment. I will take that motion right now.

MR. PENN: So moved.

MR. GREIMAN: Second.

VICE-CHAIRMAN HAYES: Voice vote.

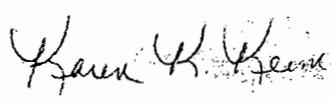
("Ayes" heard)

VICE-CHAIRMAN HAYES: The meeting is adjourned. Thank you very much.

END TIME: 4:16 P.M.

CERTIFICATE OF REPORTER

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



KAREN K. KEIM

CRR, RPR, CSR-IL, CCR-MO

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