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HEALTH FACILITIES AND SERVICES REVIEW BOARD

525 West Jefferson Street, 2nd Floor

Springfield, Illinois 62761

217-782-3516

OPEN SESSION

(December 10, 2012)

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

1 PRESENT:

2 Dale Galassie - Chairman
3 John Hayes - Vice-Chairman
4 James Burden
5 Alan Greiman
6 Kathy Olson
7 Richard Sewell
8 David Penn
9 Philip Bradley
10 Deanna Demuzio

6

7 ALSO PRESENT:

8 Courtney Avery - Administrator
9 Catherine Clark - Board Staff
10 Frank Urso - General Counsel
11 Juan Morado - Assistant Counsel
12 Alexis Kendrick - Board Staff
13 Claire Burman - Board Staff
14 Michael Constantino - IDPH Staff
15 George Roate - IDPH Staff
16 David Carvalho - IDPH
17 Bill Dart - IDPH
18 Michael C. Jones - DHFS
19 Michael Pelletier - DHS

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Reported by:

21 Karen K. Keim
22 CRR, RPR, CSR-IL, CRR-MO
23 Midwest Litigation Services
24 115 S. Lasalle Street, Suite 2600
Chicago, IL 60611

1 START TIME: 10:05 a.m.

2

3 CHAIRMAN GALASSIE: Good morning, ladies and
4 gentlemen. Happy Hannakuh/Christmas season. Winter is
5 here.

6 I would like to call this meeting to order,
7 and I would ask George for a roll call, please.

8 MR. ROATE: First roll. Mr. Bradley?

9 MR. BRADLEY: Present.

10 MR. ROATE: Dr. Burden?

11 MR. BURDEN: Here.

12 MR. ROATE: Senator Demuzio?

13 MS. DEMUZIO: Present.

14 MR. ROATE: Justice Greiman?

15 MR. GREIMAN: Here.

16 MR. ROATE: Mr. Hayes?

17 MR. HAYES: Here.

18 MR. ROATE: Ms. Olson?

19 MS. OLSON: Here.

20 MR. ROATE: Mr. Penn?

21 MR. PENN: Here.

22 MR. ROATE: Mr. Sewell?

23 MR. SEWELL: Here.

24 MR. ROATE: Chairman Galassie?

1 CHAIRMAN GALASSIE: Present.

2 MR. ROATE: Nine members present.

3 CHAIRMAN GALASSIE: Thank you.

4 Can I ask for approval of the minutes, please,
5 a motion?

6 MR. PENN: So moved.

7 MR. HAYES: Second.

8 CHAIRMAN GALASSIE: Moved and seconded. Are
9 there any questions or revisions to the minutes?

10 MR. CARVALHO: Yes, Mr. Chairman. I have two.
11 In the first day's transcript, page 207, line 18, I was
12 referring to "Kremlinologists" studying our State Agency
13 Reports, and it was recorded as "criminologists", which may
14 be back in the day. And then on the second day, on page
15 128, line 8, referred to "skilled nursing homes" and
16 transcribed as "still nursing homes". So, it should be
17 "skilled". Thank you.

18 CHAIRMAN GALASSIE: So noted. Thank you very
19 much.

20 I have a motion and a second. All in favor?

21 ("Ayes" heard)

22 CHAIRMAN GALASSIE: Opposed?

23 (No response)

24 CHAIRMAN GALASSIE: Hearing none, minutes

1 pass. Thank you very much.

2 Moving on to Agenda Item No. 6, Post Permit
3 Items Approved by the Chair. Mr. Constantino will go
4 through these items, A through H. If there are any
5 questions from Board members, we'll take them. If not, we
6 will do these in a unified vote.

7 Mike?

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

9 Permit No. 12-010, Evanston Renal Center,
10 approved for alteration to permit, October 30th, 2012.

11 Permit No. 08-050, Good Samaritan Medical
12 Office Center, approved for permit removal from December
13 31st, 2012 to June 30th, 2013.

14 Permit No. 08-051, Good Samaritan Regional
15 Health Center, approved for permit renewal from December
16 31st, 2012 to June 30th, 2013.

17 Permit No. 08-070, Good Samaritan Ambulatory
18 Surgical Center, approved for permit renewal from December
19 31st, 2012 to June 30th, 2013.

20 Permit No. 10-033, Fresenius Medical Care
21 Elmhurst, approved for permit renewal from January 1st,
22 2013 to November 30th, 2013.

23 Permit No. 11-054, Fresenius Medical Care
24 Northfield, approved for permit renewal from December 31st,

1 2013 to May 31st, 2014.

2 Permit No. 12-051, DuPage Medical Group,
3 approved for permit renewal from December 31st, 2012 to
4 April 30th, 2013.

5 Permit No. 12-074, Jacksonville Developmental
6 Center, approved for permit renewal from November 21st,
7 2012 to December 3rd, 2012.

8 Thank you, Mr. Chairman.

9 CHAIRMAN GALASSIE: Thank you, sir.

10 Are there any questions from Board members on
11 Items 6-A through 6-H?

12 (Pause)

13 CHAIRMAN GALASSIE: Hearing none, there is no
14 motion required, as these have been approved. Let the
15 record show 6-A through 6-H have been addressed. Thank
16 you.

17 Moving on to Item 7, Items for State Board
18 Action, 7-A, 7-B and -- no, sorry, 7-A-01, 7-A-02, and
19 7-A-03 do not require presentations at this time. We are
20 going to go through Item A-01, as these have been reviewed
21 and approved and there's been no opposition to these items.

22 Michael?

23 MR. CONSTANTINO: This is the second permit
24 renewal request for these items.

1 CHAIRMAN GALASSIE: And we have no
2 opposition?

3 MR. CONSTANTINO: No, there is no opposition
4 received. There haven't been any findings. They're in
5 compliance with the State Board rules.

6 CHAIRMAN GALASSIE: My intention is to
7 introduce these, ask if there is any request for public
8 comment -- although we have none that's been recorded --
9 and if there is none, forego a presentation, respectfully,
10 and bring the motion directly to the Board. Do I have
11 concurrence with that for the next three items?

12 (Pause)

13 MR. HAYES: Yes.

14 CHAIRMAN GALASSIE: Thank you very much.
15 Again, I will move forward, folks. Introducing A-01,
16 08-082, Victorian Village. Is there anyone here to speak
17 in opposition to Victorian Village?

18 (Pause)

19 CHAIRMAN GALASSIE: Or other public
20 participation?

21 (Pause)

22 CHAIRMAN GALASSIE: Hearing none, may I have a
23 motion to approve a 14-month permit renewal for Victorian
24 Village in Homer Glen, Illinois?

1 MS. OLSON: So moved.

2 MR. DEMUZIO: Second.

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

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

7 Mr. Bradley?

8 MR. BRADLEY: Yes.

9 MR. ROATE: Dr. Burden?

10 MR. BURDEN: Yes.

11 MR. ROATE: Senator Demuzio?

12 MS. DEMUZIO: Yes.

13 MR. ROATE: Justice Greiman?

14 MR. GREIMAN: Yes.

15 MR. ROATE: Mr. Hayes?

16 MR. HAYES: Yes.

17 MS. ROATE: Ms. Olson?

18 MR. OLSON: Yes.

19 MR. ROATE: Mr. Penn?

20 MR. PENN: Yes.

21 MR. ROATE: Mr. Sewell?

22 MR. SEWELL: Yes.

23 MR. ROATE: Chairman Galassie?

24 CHAIRMAN GALASSIE: Yes. And if I could ask

1 the recorder to amend the motion to include the renewal
2 dates from December 31, 2012 to February 28th, 2014.

3 Motion passes. Thank you very much.

4 Moving on to Item A-02, 08-091, Riverside
5 Medical Center. Is there anyone here to speak in
6 opposition to Riverside Medical Center?

7 (Pause)

8 CHAIRMAN GALASSIE: Hearing none, may I have
9 a motion to approve a five-month permit renewal for
10 Riverside Medical Center in Kankakee, Illinois, from
11 December 1st, 2012 to May 1st, 2013?

12 MR. BRADLEY: So moved.

13 MR. SEWELL: Second.

14 CHAIRMAN GALASSIE: Moved and seconded. Roll
15 call, please.

16 MR. ROATE: Motion made by Mr. Bradley,
17 seconded by Mr. Sewell.

18 Mr. Bradley?

19 MR. BRADLEY: Yes.

20 MR. ROATE: Dr. Burden?

21 MR. BURDEN: Yes.

22 MR. ROATE: Senator Demuzio?

23 MS. DEMUZIO: Yes.

24 MR. ROATE: Justice Greiman?

1 MR. GREIMAN: Yes.

2 MR. ROATE: Mr. Hayes?

3 MR. HAYES: Yes.

4 MR. ROATE: Ms. Olson?

5 MS. OLSON: Yes.

6 MR. ROATE: Mr. Penn?

7 MR. PENN: Yes.

8 MR. ROATE: Mr. Sewell?

9 MR. SEWELL: Yes.

10 MR. ROATE: Chairman Galassie?

11 CHAIRMAN GALASSIE: Yes.

12 MR. ROATE: Nine votes in the affirmative.

13 CHAIRMAN GALASSIE: Motion passes. Thank you

14 very much.

15 Item A-03, 09-077, Asbury Pavilion and

16 Rehabilitation Center. Anyone here to speak in opposition

17 to that issue?

18 (Pause)

19 CHAIRMAN GALASSIE: Hearing none, may I have

20 a motion to approve a six-month permit renewal for Asbury

21 Pavilion and Rehab Center in North Aurora --

22 MR. GREIMAN: So moved.

23 CHAIRMAN GALASSIE: -- from December 31st to

24 June 30th.

1 MR. GREIMAN: So moved.

2 MR. PENN: Second.

3 CHAIRMAN GALASSIE: Roll call, please?

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

6 Mr. Bradley?

7 MR. BRADLEY: Yes.

8 MR. ROATE: Dr. Burden?

9 MR. BURDEN: Yes.

10 MR. ROATE: Senator Demuzio?

11 MS. DEMUZIO: Yes.

12 MR. ROATE: Justice Greiman?

13 MR. GREIMAN: Yes.

14 MR. ROATE: Mr. Hayes?

15 MR. HAYES: Yes.

16 MR. ROATE: Ms. Olson?

17 MS. OLSON: Yes.

18 MR. ROATE: Mr. Penn?

19 MR. PENN: Yes.

20 MR. ROATE: Mr. Sewell?

21 MR. SEWELL: Yes.

22 MR. ROATE: And Chairman Galassie?

23 CHAIRMAN GALASSIE: Yes.

24 MR. ROATE: That's nine votes in the

1 affirmative.

2 CHAIRMAN GALASSIE: Motion passes.

3 Congratulations, folks. Thank you very much.

4 Moving on to Item B -- Exemption Requests --
5 on our agenda; we have none.

6 Item C, Exemption Requests -- Item B,
7 Extension Requests; we have none.

8 Item C, Exemption Requests; we have none.

9 D, Alteration Requests; we have none.

10 E, Declaratory Rulings; we have none.

11 J, Status Report on a Conditional and
12 Contingent Permit; we have one, 12-027. Good Samaritan
13 Pontiac requests to extend a condition and stipulation.

14 Michael, are you going to address this?

15 MR. CONSTANTINO: Yes.

16 CHAIRMAN GALASSIE: If you would, please,
17 introduce yourselves, be sworn in.

18 MR. CLANCY: Good morning. My name is Ed
19 Clancy.

20 MS. ARDUINO: Kelly Arduino (spells name).

21 MR. HIATT: Rick Hiatt, Good Samaritan
22 Pontiac.

23 (Oath given)

24 CHAIRMAN GALASSIE: Thank you.

1 Staff report?

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

3 The permit holders are requesting a six-month extension of
4 the time to have debt financing in place for Permit 12-072,
5 until June 2013. They're attempting to get financing from
6 the USDA. Originally they thought they would have
7 financing in place by December 31st, 2012.

8 CHAIRMAN GALASSIE: Could you just repeat
9 those dates, please?

10 MR. CONSTANTINO: The permit holders would
11 like to have a six-month extension until June 30th, 2013.
12 Originally they thought they would have debt financing in
13 place by December 31st, 2012.

14 CHAIRMAN GALASSIE: Thank you, sir. Any other
15 issues besides that?

16 MR. CONSTANTINO: No, sir.

17 CHAIRMAN GALASSIE: Folks, would you like to
18 address the Board?

19 MR. CLANCY: On a procedural matter,
20 originally we brought this request under a Request for
21 Declaratory Ruling, and that's the instructions we had
22 gotten. I see it's on the agenda as just a request.
23 Sorry. We were just following the procedures that we were
24 asked to do.

1 Mr. Rick Hiatt and Kelly Arduino can answer
2 any questions you have in terms of what they've done in
3 terms of getting this financing and any other questions you
4 have.

5 CHAIRMAN GALASSIE: Any questions on the
6 Board members' part?

7 (Pause)

8 CHAIRMAN GALASSIE: Hearing none, may I have a
9 motion to approve the request to extend the conditions and
10 stipulations placed on Permit No. 12-027, Good Samaritan
11 Pontiac, Pontiac, Illinois until June 30th, 2013?

12 MR. SEWELL: So moved.

13 MR. HAYES: Second.

14 CHAIRMAN GALASSIE: Moved and seconded. Roll
15 call, please.

16 MR. ROATE: Motion made by Mr. Sewell,
17 seconded by Mr. Hayes.

18 Mr. Bradley?

19 MR. BRADLEY: Yes.

20 MR. ROATE: Dr. Burden?

21 MR. BURDEN: Yes.

22 MR. ROATE: Senator Demuzio?

23 MS. DEMUZIO: Yes.

24 MR. ROATE: Justice Greiman?

1 MR. GREIMAN: Yes.

2 MR. ROATE: Mr. Hayes?

3 MR. HAYES: Yes.

4 MR. ROATE: Ms. Olson?

5 MS. OLSON: No, based on financing.

6 MR. ROATE: Mr. Penn?

7 MR. PENN: Yes.

8 MR. ROATE: Mr. Sewell?

9 MR. SEWELL: Yes.

10 MR. ROATE: Chairman Galassie?

11 CHAIRMAN GALASSIE: Just before Chairman
12 votes, we assume that you feel this is enough time, by June
13 13th, to have your funding in place.

14 MR. HIATT: At this time we feel that.

15 CHAIRMAN GALASSIE: Thank you very much.

16 Chair votes yes.

17 MR. ROATE: That's eight votes in the
18 affirmative, one vote in the negative.

19 CHAIRMAN GALASSIE: Motion passes. Thank you.
20 Good luck.

21 MR. CLANCY: One other point is, we would also
22 need an extension on the completion date. Do we ask for
23 that at this time, or do we have to come back?

24 CHAIRMAN GALASSIE: Only one bite at the

1 apple this morning.

2 Moving on to Item No. F, Healthcare Workers
3 Self-Referral; we have none.

4 Item G, Alternative Healthcare Delivery Act;
5 we have none.

6 We're now moving into our traditional
7 Applications Subsequent to Initial Review. We have one
8 application -- the first application, H-01 -- that has
9 no -- I'm sorry. It meets all off your criteria. Staff
10 has no issues. There is no opposition. I will suggest we
11 forego a presentation, pending -- is there anyone here to
12 speak in opposition to the FMC Galesburg project?

13 (Pause)

14 CHAIRMAN GALASSIE: Hearing none, I would ask
15 for a motion from the Board. May I have a motion to
16 approve Project 12-082?

17 MR. DEMUZIO: Motion.

18 MS. OLSON: Second.

19 CHAIRMAN GALASSIE: Motion and second. All
20 in favor?

21 MR. ROATE: Motion made by Senator Demuzio,
22 seconded by Ms. Olson. Mr. Bradley?

23 MR. BRADLEY: Yes.

24 MR. ROATE: Dr. Burden?

1 MR. BURDEN: Yes.

2 MR. ROATE: Senator Demuzio?

3 MS. DEMUZIO: Yes.

4 MR. ROATE: Justice Greiman?

5 MR. GREIMAN: Yes.

6 MR. ROATE: Mr. Hayes?

7 MR. HAYES: Yes.

8 MR. ROATE: Ms. Olson?

9 MS. OLSON: Yes.

10 MR. ROATE: Mr. Penn?

11 MR. PENN: Yes.

12 MR. ROATE: Mr. Sewell?

13 MR. SEWELL: Yes.

14 MR. ROATE: Chairman Galassie?

15 CHAIRMAN GALASSIE: Yes.

16 MR. ROATE: Nine votes in the affirmative.

17 CHAIRMAN GALASSIE: Motion passes. Thank you

18 very much. Good luck. The easy ones are over.

19 Moving on to Item H-02 on our agenda, 12-079,

20 Holy Cross Hospital, we have four individuals who have

21 requested to make comment. Courtney will read those four

22 names, and we'll ask you folks to come up. You do not have

23 to be sworn in for public comment, but if you'll come up

24 and we'll go one by one. In case you're new to the room,

1 you have a two-minute limitation. Juan will give you a
2 minute and a half warning, and for everyone else's respect
3 of time, we will cut you off at the end of two minutes, if
4 you are not finished. So, if these folks would please come
5 to the front of the room.

6 MS. AVERY: We have Dennis Ryan, Toni Foulkes,
7 Dr. Ahuja, and Jeff Bartow.

8 (Pause)

9 MR. CARVALHO: Mr. Chair? Dave Carvalho. I
10 have a conflict of interest with respect to this
11 application, and as is our custom, I'll step away from the
12 table. I do want to note for the record that, because of
13 my conflict, I participated in no way in review or
14 processing of this application. Thank you.

15 CHAIRMAN GALASSIE: Thank you, sir.

16 We'll start with this young man here. If you
17 would, please introduce yourself, and feel free to address
18 the Board.

19 MR. RYAN: Thanks for the "young man" part.
20 I'm Dennis Ryan, and this letter was received at about 5:30
21 on Friday. I'd like to have it entered into the record.
22 It's from the Archdiocese of Chicago, Vicar for Healthcare,
23 December 7th, 2012, to Ms. Courtney Avery.

24 "Dear Ms. Avery: I understand that a question

1 has been asked regarding Archdiocesan and Vatican approval
2 of the transition of Holy Cross Hospital to the Sinai
3 Health System.

4 This letter will confirm that, pursuant to
5 Canon Law and Vatican practice, Cardinal George gave his
6 nihil obstate (non objection) to Holy Cross joining the
7 Sinai System and Vatican approval was granted. It is my
8 understanding that this approval was previously filed with
9 the Board. Holy Cross will continue to be recognized as a
10 Catholic hospital after joining the Sinai Health System.

11 Yours sincerely, William Grogan, Reverend
12 William P. Grogan, Vicar for Healthcare."

13 CHAIRMAN GALASSIE: Thank you, Mr. Ryan.

14 There were some questions at our pre-meeting
15 with Board of Health for Board members' understanding, and
16 we wanted to make sure that we had had approval, and thus
17 that letter was submitted. Thank you very much.

18 Next, please.

19 MS. FOULKES: Good Morning. Alderman Toni
20 Foulkes, 15th Ward, City of Chicago.

21 The Sisters of St. Casimir has been a pillar
22 of the Marquette Park community for as long as anyone can
23 remember. In addition to their mission of education,
24 healthcare, and feeding the hungry, their commitment has

1 been steadfast through many community challenges of
2 prejudice, discrimination, predatory lending, home
3 foreclosures, unemployment, and other hits from a deeply
4 economic crisis.

5 The partnership will, A, keep and approve a
6 central community health services to one of Illinois'
7 deep -- excuse me; I hate reading -- to one of Illinois'
8 deepest, busiest emergency rooms with the most ambulance
9 runs in the state, that serves two of the most violent
10 police districts in the City of Chicago. It also expands
11 options for specialty care, quality health, and chronic
12 disease management. It also keeps necessary jobs in the
13 community. Holy Cross is the third largest employee of the
14 community.

15 The partnership will allow Holy Cross to
16 remain one of the proactive forces for a strong and healthy
17 community. The Sisters of Casimir have chosen to become
18 one -- to become a part of Sinai's Health System because
19 they believe that this is the best option to keep their
20 mission of providing quality care to a community alive and
21 strong.

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

24 Good morning, sir.

1 MR. AHUJA: Good morning, ladies and
2 gentlemen. My name is Dr. Satya Ahuja. I'm the President
3 of the medical staff of Holy Cross Hospital.

4 We have over 220 active members, physicians at
5 the hospital. Our hospital has struggled in the last two
6 decades. The communities surrounding the Holy Cross
7 Hospital has changed in the last two decades, and they're
8 very much underserved. With the cuts in Medicare and
9 Medicaid, survival of a lone hospital that is not part of a
10 system will become much more difficult.

11 Sinai Hospital System has many medical
12 services, specialties, and technologies that Holy Cross
13 Hospital does not have. Together we will have
14 complementary capabilities. Sinai Health System has
15 developed innovative programs to serve underserved
16 populations, like Holy Cross Hospital serves. Both Sinai
17 and Holy Cross Hospital will be stronger together than
18 separate in addressing particular health needs on Chicago's
19 west and southwest sides.

20 Thank you.

21 CHAIRMAN GALASSIE: Thank you. Appreciate
22 your comments.

23 Good morning, sir.

24 MR. BARTOW: Good morning. My name is Jeff

1 Bartow. I'm the Executor Director of the Southwest
2 Organizing Project on the southwest side of Chicago. We
3 were established in 1996. We have 28 member institutions,
4 including 9 large Catholic parishes. Our member
5 institutions include about 35,000 people.

6 Since its inception, SWOP has worked closely
7 with the Sisters of St. Casimir, who play an important and
8 highly respected role in the public life of southwest
9 Chicago. Whether the issue is healthcare, education,
10 housing, public safety, or local leadership development,
11 the Sisters of St. Casimir are there, actively helping
12 shape workable, strong solutions to the challenges faced by
13 families on the southwest side of the city.

14 Holy Cross Hospital is an institution of
15 critical importance in our community. It provides crucial
16 health services in an area which is some distance from
17 other hospitals. Its Emergency Room, with the high
18 incidents of stroke as well as cardiac illness in our
19 neighborhoods, is a vital resource. The in-patient hospice
20 is a key aspect to the care and well-being of our families,
21 as well. Holy Cross Hospital also has a strong commitment
22 to other local organizations and provides support and
23 leadership to many of them. The hospital, with over a
24 thousand employees, is also the second largest employer in

1 the economically-challenged area that it serves.

2 MR. MORADO: Thirty seconds.

3 MR. BARTOW: Ours is a diverse community, and
4 there's a strong need for institutions to work together, if
5 we're going to succeed as a neighborhood.

6 I've lived in the community 20 years. I have
7 been in the position I'm in now for over 10 years, and I
8 have never heard of an organization that appeared in the
9 record, the Lithuanian Roman Catholic Charity group. They
10 have not participated in or contributed to community
11 building or development in my history, and no community
12 leaders I know have ever worked with them.

13 We strongly support the merger between Sinai
14 and Holy Cross Hospital. Thank you.

15 CHAIRMAN GALASSIE: Thank you for your
16 comments. To all of you, good morning.

17 (Pause)

18 CHAIRMAN GALASSIE: Thank you. And if there
19 are any representatives from Holy Cross Hospital, we would
20 invite you to the table. If you would, please introduce
21 yourselves and spell your names for the record, and we'll
22 have you sworn in. Good morning, all. If you would pull
23 the microphones in front of yourself when you are speaking.

24 MS. WENDT: I'm Sister Immacula, General

1 Superior for the Sisters of St. Casimir (spells name).

2 CHAIRMAN GALASSIE: Thank you.

3 MR. LERNER: Wayne Lerner (spells name),
4 President of Holy Cross Hospital.

5 MR. CHANNING: Alan Channing, President, Sinai
6 Health System (spells name).

7 MR. AXEL: Jack Axel, Axel and Associates.
8 (Oath given)

9 CHAIRMAN GALASSIE: Staff report, please.

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

11 The applicants are proposing a change of
12 ownership of Holy Cross Hospital, a 274-bed acute care
13 hospital in Chicago, Illinois. The fair market value of
14 the hospital is \$18.6 million. The anticipated project
15 completion date is March 31st, 2013.

16 Thank you, Mr. Chairman.

17 CHAIRMAN GALASSIE: Thank you.

18 Comments for the Board, gentlemen?

19 MS. WENDT: Good morning again. I'm Sister
20 Immacula Wendt, the General Superior of the Sisters of St.
21 Casimir, the sponsoring religious order of Holy Cross
22 Hospital, and I have been a Trustee of the hospital for 26
23 years. With me are Alan Channing, the President and CEO of
24 Sinai Health, Wayne Lerner, the President and CEO of Holy

1 Cross, and Jack Axel, our CON consultant.

2 In line with the mission of Holy Cross
3 Hospital and the Sisters of St. Casimir, our commitment to
4 care for the residents of the neighborhoods and communities
5 we serve has remained steadfast over the years, even
6 through the financial difficulties and challenges of recent
7 years. When my tenure on the Holy Cross Hospital Board
8 began, it was felt that Holy Cross could meet the
9 increasing changes in healthcare and remain a stand-alone
10 hospital. Today, the reality is that Holy Cross simply
11 cannot continue to operate as a hospital without becoming a
12 member of a larger system. Further, due to the aging of
13 our congregation, we can no longer adequately provide the
14 governance required to responsibly manage this vital
15 mission.

16 As some of you may recall, we appeared before
17 you March 2011, to seek your approval for Holy Cross to
18 become a part a national system. A Certificate of Need
19 permit was granted for us to do so; but, unfortunately,
20 that proposed acquisition did not take place.

21 Through the extraordinary work of our
22 management team in the last year, we have been able to
23 maintain a very small profit, paring our operating costs to
24 the bone; but the economic environment, healthcare reforms,

1 and rapid changes in technology, quality improvement, and
2 health practices make our solitary situation ever more at
3 risk. After the hospital sale that you approved did not
4 materialize, we renewed our search and were unable to find
5 a regional, local, or national healthcare system interested
6 in acquiring Holy Cross that would meet our
7 carefully-considered criteria. We believe that a viable
8 partner must be able to strengthen the hospital by
9 enhancing its business strategy, providing more complete
10 continuum of care, limit duplication, and deliver
11 complementary care services.

12 The change of governance that we are bringing
13 before you this morning is certainly not about money;
14 rather, it is about critical community health needs and
15 maintaining a hospital to serve them. Sinai Health System
16 has offered, and pending your approval, we have accepted a
17 proposal from Holy Cross Hospital to become a member of the
18 Sinai Health System. In this partnership, as approved by
19 Cardinal George and the Vatican Congregation of Consecrated
20 Life and Society of Apostolic Life, Holy Cross will remain
21 a Catholic hospital and will adhere to all of the United
22 States Catholic -- Conference of Catholic Bishop's ethical
23 and religious directives for Catholic healthcare. The
24 Sisters of St. Casimir will remain the religious sponsors

1 of the hospital.

2 We are both grateful and excited that Sinai
3 Health System shares a very similar commitment to the
4 mission of quality care for the underserved and respects
5 our faith heritage. Our decisions to seek a partner and
6 subsequently join the Sinai Health Systems were made with a
7 great deal of evaluation, due diligence, and prayer. We
8 are -- we care deeply about Holy Cross, its mission, and
9 the need to remain steadfast to the community we serve, the
10 people we employ, and the doctors who care for our
11 patients.

12 Once the decision was made to evaluate
13 opportunities, some three years ago, we identified three
14 key criteria for any partner: A commitment to the
15 provision of high quality care; a commitment to operate
16 Holy Cross as a Catholic hospital; the ability and
17 willingness to sustain necessary hospital services and
18 complement those already in existence at Holy Cross. In
19 Sinai Health System, we have found a partner committed to
20 all three of these critical criteria.

21 And with this introduction, I will turn the
22 microphone over to Alan to conclude our comments.

23 CHAIRMAN GALASSIE: Thank you, Sister.

24 MR. CHANNING: Thank you, Sister.

1 Mr. Chairman, Members of the Board. My
2 comments will be brief.

3 Sinai Health System and particularly Mount
4 Sinai Hospital and Holy Cross Hospital, aside from our
5 religion affiliations, have a great deal in common. We
6 both are, by any definition, safety net hospitals,
7 providing essential healthcare services to among the most
8 financially challenged populations in the Chicago area.

9 As noted in the SAR, in 2011, 46 percent of
10 Sinai's admissions and 34 percent of those to Holy Cross
11 were Medicaid recipients. We treat service areas that
12 overlap. We're both committed to the neighborhoods we
13 serve. We are both accustomed to finding ways to stretch
14 the dollars that we have.

15 The \$18 million projected project cost
16 identified in the SAR, as Staff reported, is the estimated
17 fair market value of Holy Cross Hospital. There is no cash
18 changing hands in this transaction. We believe that Holy
19 Cross Hospital joining the Sinai Hospital allows both to
20 spread our operating costs over a larger organization.
21 Through the sharing of programs, management expertise, and
22 operational systems, we can both benefit.

23 In our due diligence process, we engaged
24 national experts to assess and review our purpose and our

1 goals. Their evaluation confirmed the viability of our
2 strategic plan. Over the next year we are will evaluating
3 every clinical and non-clinical program, at both Mount
4 Sinai and Holy Cross, to identify how best practices can be
5 duplicated and how redundant services can be consolidated.

6 Thank you for the opportunity to appear before
7 you. Our proposal has been deemed by your Staff to be
8 consistent with all the review criteria, and we would be
9 happy to answer any questions you may have.

10 CHAIRMAN GALASSIE: Thank you, sir.

11 I'd like to open it up now for Board
12 questions. Any questions from Board members.

13 Dr. Burden?

14 MR. BURDEN: I'd just like to comment
15 positively about what I see as a major concern of mine
16 personally, as a practicing physician in Chicago in the
17 area for 45 years and having friends that worked at both
18 institutions that are now merging. I applaud this. I'm
19 concerned, obviously, because we do see the need, in my
20 judgment, of looking at the inner city vulnerable
21 population to have access to quality medical care. When I
22 was aware that Vanguard had elected not to pursue, it
23 showed me the pattern that I see in the for-profit
24 industry, and we've seen it time and again. We're going to

1 see more.

2 I'm very hopeful that you will be successful
3 in your merger, as I am aware of others institutions in the
4 city -- that you are, of course, aware of -- that had to
5 seek out help from larger, financially viable. We're
6 coming into a very difficult time. My fellow physicians --
7 I'm retired for 13 years. I hear it constantly about
8 reimbursement rates, problems of a great nature. We're
9 also looking at a major change. I'm hopeful. I think it's
10 admirable and great that Mount Sinai is able to reach out
11 and do this. I'm aware of that institution from friends of
12 mine. The Russian Jewish community has supported that
13 hospital during very tough times. I'm just commenting
14 about how I think it is a strategic maneuver, which I
15 believe in, and hope in my heart that it will be as
16 successful as you all hope.

17 CHAIRMAN GALASSIE: Other questions from
18 Board members?

19 (Pause)

20 MR. BRADLEY: I have a comment. When I went
21 to work for the Department of Public Aid, the first visit I
22 made was to the emergency room at Holy Cross, and the
23 second visit I made was to the emergency room at Mount
24 Sinai, which gives you some idea what the staff thought of

1 the importance of these two institutions. They've stayed
2 in their communities. They serve underserved people, some
3 of whom are Medicaid, many of whom are uninsured, all of
4 whom who have tremendous health needs. I think it's
5 wonderful that these two institutions are getting together.
6 I think they share the same mission, and in Sinai, they
7 have a partner who understands how you can function and not
8 lose money in a very difficult financial environment. So,
9 I wish them both well.

10 CHAIRMAN GALASSIE: Thank you, Member
11 Bradley. Do you want to mention the year you started
12 Public Aid?

13 MR. BRADLEY: No, but it was as bad then as it
14 is now, unfortunately.

15 MR. SEWELL: I just want to ask a question
16 about the uniqueness of this. Do you know of other systems
17 that have partners that have different faith systems?

18 MR. CHANNING: Thanks for the question. If I
19 understand it correctly, the difference in the faith
20 backgrounds?

21 MR. SEWELL: Yeah.

22 MR. CHANNING: There are several, literally,
23 around the country. I think the most recent was in
24 Detroit. A Catholic hospital and Jewish hospital heritage

1 came together. I think probably the biggest that most of
2 us are familiar with was the coming together in St. Louis
3 of BJC. So, there have been a number of models across the
4 country that have been successful.

5 MR. BARTOW: That actually goes back almost 40
6 years ago. Hartford, Connecticut was the first one I'm
7 aware of where a Jewish hospital and Catholic hospital
8 merged together, while respecting each others faith
9 heritages. So, this is not new news, and it really does --
10 as the Board members said, it generates from the common
11 mission of the two organizations.

12 CHAIRMAN GALASSIE: Any other questions from
13 Board members?

14 (Pause)

15 CHAIRMAN GALASSIE: Hearing none, may I have a
16 motion to approve Project 12-079, Holy Cross Hospital.

17 MR. GREIMAN: So moved.

18 MR. SEWELL: Second.

19 CHAIRMAN GALASSIE: Moved and seconded.

20 MR. ROATE: Motion made by Justice Greiman,
21 seconded by Mr. Sewell. Mr. Bradley?

22 MR. BRADLEY: Yes.

23 MR. ROATE: Dr. Burden?

24 MR. BURDEN: Yes.

1 MR. ROATE: Senator Demuzio?

2 MS. DEMUZIO: Yes.

3 MR. ROATE: Justice Greiman?

4 MR. GREIMAN: Yes.

5 MR. ROATE: Mr. Hayes?

6 MR. HAYES: Yes.

7 MR. ROATE: Ms. Olson?

8 MS. OLSON: Yes.

9 MR. ROATE: Mr. Penn?

10 MR. PENN: Yes.

11 MR. ROATE: Mr. Sewell?

12 MR. SEWELL: Yes.

13 MR. ROATE: Chairman Galassie?

14 CHAIRMAN GALASSIE: Yes.

15 MR. ROATE: Nine votes in the affirmative.

16 CHAIRMAN GALASSIE: Motion passes.

17 Congratulations. Thank you very much. Creative

18 partnership. The Chair is having difficulty keeping up

19 with Board members.

20 Moving on to Item H-03, Ottawa Pavilion. We

21 have no public participation comment. Representatives from

22 Ottawa Pavilion are welcome to come to the front, to the

23 table.

24 (Pause)

1 CHAIRMAN GALASSIE: Good morning, ladies and
2 gentlemen. If you wouldn't mind introducing yourselves and
3 spelling your names with the microphone close to your
4 mouths.

5 MR. SHEETS: Chuck Sheets from Polsinelli
6 Shughart (spells name).

7 MS. LYLE: Margie Lyle, the Administrator of
8 Ottawa Pavilion (spells name).

9 MR. MAUER: Marshall Mauer, one of the owners
10 of Ottawa Pavilion (spells name).

11 MS. COOPER: Anne Cooper (spells name),
12 Polsinelli Shughart.

13 CHAIRMAN GALASSIE: Good morning, folks.

14 (Oath given)

15 CHAIRMAN GALASSIE: Thank you.

16 Michael, do we have a Staff report?

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

18 The applicants are proposing to modernize and
19 replace the existing buildings and add 10 long-term care
20 beds, for a total of 129 beds, at a cost of approximately
21 \$19 million. This project was originally approved back in
22 April of 2010. Subsequently, in June of 2012, the permit
23 was deemed invalid for failure to comply with the
24 post-permit requirements, and the project costs exceeded

1 the allowable permit amount. In September of 2012, a Final
2 Order was issued, whereby the parties agreed to file a
3 second application, and that's what you see in front of you
4 today.

5 Thank you, Mr. Chairman.

6 CHAIRMAN GALASSIE: Thank you.

7 Would you like to address the Board?

8 MR. SHEETS: Briefly. Members of the Board, I
9 think there's one correction I'd like to make. I think the
10 Final Order would be entered, hopefully, today.

11 Frank, is that accurate?

12 MR. URSO: The Final Order will probably be
13 presented at the next meeting. We do have a Settlement
14 Agreement. We've been able to resolve this matter in a
15 very positive way. So, we want to thank them for working
16 with us to revolve this matter, and we should have a Final
17 Order for the Board at the next meeting.

18 MR. SHEETS: Thank you.

19 I'd like Mr. Mauer to basically introduce the
20 project and explain to the Board members who weren't here
21 what we're dealing with.

22 MR. MAUER: Good morning. As I said, my name
23 is Marshall Mauer. I'm one of the owners of Ottawa
24 Pavilion. With me are Marge Lyle, the Administrator for

1 Ottawa Pavilion, and Chuck Sheets, who assisted us in
2 preparing the CON application.

3 This project was previously approved by the
4 Board in April 2010. For those members who were not
5 present the last time this project was before the Board, I
6 would like to briefly describe the project. This project
7 involved the modernization and replacement of an existing
8 building on the Ottawa campus. The original building was
9 built in 1920 as a sanitarium. Over time, the building has
10 deteriorated and is used only for limited storage. With
11 the exception of the storage area, most of the original
12 building was replaced in 1940 and is referred to as the
13 Main Building. A third building, known as the Annex, was
14 constructed in 1989 and houses 32 skilled nursing beds and
15 requires significant updates. These buildings are
16 insufficient to meet the needs of today's seniors.

17 Additionally, due to the aged configuration of
18 the buildings, they are in constant need of repair, and
19 maintenance has become cost prohibitive. Over the past
20 decade, maintenance costs have nearly doubled, and we have
21 made over \$2 million in capital improvements to the
22 buildings. This project will provide high quality,
23 state-of-the-art, skilled nursing care for our current and
24 future residents.

1 This project consists of several components:
2 One, construction of a new building to house 69 skilled
3 nursing beds; two, demolition of the main building; three,
4 modernization of the Annex that will house 32 skilled
5 nursing beds; and, four, construction of a new 28-bed
6 Alzheimer's unit. In designing the new building, we
7 listened carefully to our residents' suggestions.

8 At this point in time, I would like to have
9 Margie Lyle, Ottawa Pavilion's Administrator, go into
10 details about the amenities of the new building.

11 MS. LYLE: Good morning. I just want to go
12 over some of the amenities that are in the new building.

13 The main concept was a Main Street concept. I
14 had brought pictures, but I understand I can't share those
15 with you. I apologize for not getting them to you sooner.

16 When we listened to the residents and family,
17 we wanted to provide for them what we felt would meet their
18 needs and it ended up being what we call a Main Street
19 concept. It's the hub of the nursing home. All the wings
20 filter into the Main Street, and in there we have different
21 amenities, such as a private family dining, where families
22 can come and have special events, birthday parties,
23 holidays, or just get together and have a pizza. In the
24 Sports Lounge, we have a large, flat-screen TV on the wall,

1 and they daily go in there and watch the current event
2 that's taking place with their families. They can play
3 card games, board games. The Ice Cream Parlor and Popcorn
4 Parlor are also a part of our Main Street. Daily we're
5 serving popcorn from eleven in the morning, and in the
6 afternoon, they line up for the ice cream -- not only the
7 residents, but the families as well. Our Tuscany Room is
8 where we have social events. Generally, we have a social
9 hour between four and five, where we can serve hors
10 d'oeuvres and beverages. Also, we have alcoholic and
11 non-alcoholic beverages that we serve.

12 The Internet Cafe has been a great hit. We
13 open about 9:30 in the morning, and we start serving
14 coffee. We have family members that come in, and after
15 they're done visiting, they end up in the Internet Cafe for
16 just a cup of coffee. We have a computer there, and our
17 Event Aides are working with the residents. Our newest
18 project was setting up Skype. We have a resident there
19 whose daughter lived in Italy, and she was able to Skype
20 back and forth every day with her daughter. Our whole
21 facility is set up with wi-fi.

22 Just after Thanksgiving, we opened a Gift
23 Shop, which features holiday items and everyday gifts. We
24 also have a Library, which allows our residents to go and

1 sit in front of a fireplace and have a quiet time with
2 reading.

3 Our rooms are also, I think, rather unique,
4 coming out of the old building. Each bed is fully
5 electric, so the resident can control it at all times.
6 Each resident has their own 32-inch, wall-mounted TV on the
7 wall. The rooms are individually controlled by their
8 thermostat. So if they -- you know, one room can be warmer
9 than the other, or they can have air-conditioning. They
10 each have a complete bathroom with a shower with a sit-down
11 bench, and what I like best of all is the fact that we do
12 have emergency outlets in each room. So, no matter what
13 the need of that resident is, we can meet that with the
14 generator.

15 Our therapy suite is 2,900 square feet, and
16 it's basically state-of-the-art.

17 In the old building, we used to have maybe
18 ten, twelve people a day, family members, come in to visit.
19 Since we've opened the doors in our new building, we are
20 exceeding sixty people a day, not just families, but now
21 we're getting friends to come in, and they don't just stay
22 for a couple minutes. They are basically enjoying and
23 using the facilities in the Main Street that we have.

24 Thank you.

1 CHAIRMAN GALASSIE: Thank you.

2 MR. MAUER: If I can continue, I would like to
3 address the compliance issues that the Board Staff noted in
4 the State Agency Report. The project had an initial
5 completion date of March 31st, 2012 but the permit was not
6 renewed. This project consists of two phases. The first
7 phase included construction of the new wing, the core,
8 kitchen, basement, and administrative offices. The second
9 phase consists of gutting and full rehab of the Annex,
10 demolition of the Main Building, and construction of the
11 Alzheimer's unit.

12 The architect for this project was unfamiliar
13 with the Board's rules regarding completion. He assumed
14 the project was complete March 31st, 2012, when
15 construction of the new building was finished. He did not
16 understand the project included both phases of
17 construction. As a result, the original permit was not
18 renewed.

19 With respect to the project costs, we relied
20 on the architect, who estimated the cost of this project,
21 which were grossly under estimated. First, the architect,
22 who primarily designs facilities in southern Illinois and
23 Missouri, based his estimates on the use of non-union
24 labor. Because this is a union job, labor costs were

1 thirty percent higher than the architect's estimate.
2 Further, the cost estimates were done in 2008. Not only
3 did the architect not adjust the cost of building materials
4 for inflation, but he thought construction costs would
5 decrease due to the housing bubble burst. The project cost
6 savings never materialized.

7 Given our history with the architect, we
8 included a significant cushion in our projected costs in
9 this new application, to ensure that we could complete the
10 second phase of the project without exceeding the new
11 permit amount.

12 I would like to briefly address the negative
13 findings in the State Agency Report. We are proposing a
14 modernization and expansion of Ottawa Pavilion and are
15 requesting adding 10 long-term care beds to our existing
16 119 beds. The Board Staff found that based upon our 2011
17 utilization, Ottawa Pavilion could only justify 107 beds,
18 based on the Board's 90 percent utilization standard.
19 Please note we only had 104 beds set up, in use, at the old
20 building. We, therefore, had an occupancy rate of over 90
21 percent of the beds set up.

22 It is also important to understand that
23 because of ongoing construction, we did not operate our
24 full bed complement. Currently, we have 88 beds set up and

1 are completely full. In fact, since July, when the new
2 building opened, we have had to turn away on the average
3 two or three people per day. We believe once the project
4 is complete, we will quickly be operating at 90 percent
5 occupancy.

6 The total square footage for the new,
7 modernized building is 79,186 gross square feet, or 613.7
8 square feet per bed, which exceeds the State standard by
9 5,638 square feet, or 43.7 gross square feet per bed. The
10 additional square footage is needed for problematic,
11 clinical and operational needs. The new, modernized
12 building will consist of 49 private and 40 semi-private
13 rooms with each having its own bathroom and shower. The
14 inclusion of more private rooms and all private baths
15 necessitates additional space to comply with IDPH licensure
16 standards. Importantly, the square footage per room is
17 consistent with other projects recently approved by the
18 Board.

19 The modernization costs exceed the State Board
20 standards by \$268.44 per square foot. The excess cost is
21 due to the size and complexity of the modernization
22 project. Modernization costs include demolition of the new
23 building, gutting and full rehab of the Annex, and asbestos
24 removal. Further, we will re-brick and re-side the Annex

1 so there is a seamless integration of the new building and
2 the Annex.

3 Finally, I would like to thank the State Board
4 Staff and Counsel for their technical assistance in
5 handling the compliance issues with the original permit in
6 preparing this application. I respectfully request the
7 Board approve the modernization and expansion of Ottawa
8 Pavilion.

9 I will be happy to answer any questions the
10 Board may have. Thank you.

11 CHAIRMAN GALASSIE: Thank you, Mr. Mauer, and
12 I will now open it up to questions from Board members.

13 MR. PENN: I have one. You just stated you
14 turn away two to three people per day. You've turned down
15 between 300 to 450 people since July.

16 MR. MAUER: Yes.

17 MS. LYLE: I was looking at the records in the
18 last couple weeks, because I don't have them,
19 unfortunately, since we moved in July. Last week we turned
20 down nine Medicare and two Medicaid residents, and the week
21 before, we had a significant number. I didn't keep them.
22 Once we're not able to take them, I don't keep their files.

23 CHAIRMAN GALASSIE: Thank you.

24 Other questions by Board members?

1 MR. BURDEN: Mr. Chairman.

2 I want to compliment Mr. Sheets, that finally
3 he has a five-star rated nursing home to represent.

4 MR. SHEETS: Thank you, Dr. Burden. As you
5 noted, I didn't bring that up.

6 CHAIRMAN GALASSIE: Any other questions?

7 (Pause)

8 MS. OLSON: So, is it your intention to
9 continue to admit Medicaid residents in the facility.

10 MS. LYLE: Yes, it is. We currently have 37
11 Medicaid residents -- this was as of Saturday -- 23
12 private, and 27 Medicare. We had one resident pass away.
13 But, yes, we are going to continue. It's the philosophy
14 with which we built our reputation in the community,
15 helping people from all walks of life, and when I spoke
16 with the owners, that is the tradition that we are going to
17 continue with.

18 MS. OLSON: Thank you.

19 MR. HAYES: What is the -- what was the
20 Medicare star rating before this project began?

21 MR. SHEETS: Well, the last time we came
22 before you, it was three stars. So it has gone up two
23 stars.

24 MR. HAYES: And what is the completion of the

1 project now, the estimated percentage of completion?

2 MR. SHEETS: Well, we're at 85 percent, I
3 believe, right now. Is that accurate? And we're looking
4 at a February completion date. But we built in a little
5 cushion, based on the State finding issues with the rehab.
6 They're currently in the middle of rehabbing the existing
7 building, and there are a lot of tricky issues with that.
8 So, we've asked for a completion date of October of next
9 year.

10 MR. HAYES: Now, will the -- originally, was
11 the original building going to be torn down.

12 MR. SHEETS: Part of the original building was
13 torn down, and that was part of the plan. Unfortunately,
14 when the project was designed, I think there was a
15 misconception of when it was going to be completed, and, as
16 Mr. Mauer explained, the architect felt that once the new
17 building had housed the majority of the residents was done,
18 the project was over. He didn't understand that the
19 demolition and the rehab had to take place before the
20 project was officially completed.

21 MR. HAYES: Thank you.

22 CHAIRMAN GALASSIE: Hearing no other
23 questions, may I have a motion to approve Project 12-063,
24 Ottawa Pavilion, authorizing the establishment of a 129-bed

1 long-term care facility in Ottawa, Illinois?

2 MR. PENN: So moved.

3 MS. OLSON: Second.

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

6 MR. ROATE: Motion made by Mr. Penn, seconded
7 by Ms. Olson.

8 Mr. Bradley?

9 MR. BRADLEY: Yes.

10 MR. ROATE: Dr. Burden?

11 MR. BURDEN: Yes.

12 MR. ROATE: Senator Demuzio?

13 MS. DEMUZIO: Yes.

14 MR. ROATE: Justice Greiman?

15 MR. GREIMAN: Yes.

16 MR. ROATE: Mr. Hayes?

17 MR. HAYES: Yes.

18 MR. ROATE: Ms. Olson?

19 MS. OLSON: Yes.

20 MR. ROATE: Mr. Penn?

21 MR. PENN: Yes.

22 MR. ROATE: Mr. Sewell?

23 MR. SEWELL: No. It doesn't appear to have
24 utilization to justify the additional beds.

1 MR. ROATE: Thank you, sir.

2 Chairman Galassie.

3 CHAIRMAN GALASSIE: Yes.

4 MR. ROATE: That's eight votes in the
5 affirmative, one vote in the negative.

6 CHAIRMAN GALASSIE: Motion passes.
7 Congratulations. Good luck.

8 (Pause)

9 CHAIRMAN GALASSIE: Moving on to Item H-04 on
10 the agenda, 12-083, Springfield Nursing and Rehabilitation
11 Center. We have no public participation requests, so if
12 representatives from Springfield Nursing would come to the
13 table and introduce yourselves; pull in the microphones
14 close; spell your names, please. We'll get you sworn in.

15 MR. KNIERY: Good morning, Mr. Chairman. My
16 name is John Kniery (spells name) with Foley and
17 Associates.

18 MR. LEVINSON: My name is Bryan Levinson
19 (spells name), representing Springfield rehab.

20 MR. GROGG: My name is Edward Grogg (spells
21 name), representing M S Springfield.

22 MR. FOLEY: Good morning. My name is Charles
23 Foley (spells name).

24 (Oath given)

1 CHAIRMAN GALASSIE: Good morning.

2 Staff report, please?

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

4 The applicants are proposing the establishment of a 75-bed
5 long-term care facility in Springfield, Illinois. The
6 expected cost of the project is \$13.6 million. The
7 anticipated project completion date is June 30th, 2013.
8 This project was originally approved in April of 2009 at a
9 cost of \$12.9 million. In September of 2012, the Permit
10 No. 08-086 was deemed invalid for failure to comply with
11 the post-permit requirements and the permit being
12 transferred was without State Board approval. In October
13 of 2012, a Final Order was issued, whereby the parties
14 agreed to file a second application for permit to complete
15 the project with a valid permit.

16 Thank you, Mr. Chairman.

17 CHAIRMAN GALASSIE: Thank you.

18 Comments for the Board, gentlemen?

19 MR. KNIERY: In respect for your time, we'd
20 just like to open it up for questions.

21 CHAIRMAN GALASSIE: We appreciate that
22 greatly.

23 I'd like to open it up for questions from the
24 Board. Thank you.

1 MS. OLSON: Why was the permit invalid? Same
2 architect?

3 MR. KNIERY: No, it was a different architect.

4 MR. LEVINSON: Thank you for the question.

5 The permit was invalidated because, in the
6 process of finding financing on the project when we
7 initially were granted the CON, the economy was in a
8 different state. Banking was in a different situation, and
9 through the process of developing the project, we reached
10 out to a partner in development and changed the financing,
11 and in our lack of knowledge and experience in the CON
12 process, we didn't inform the Board of the change in that
13 financing. Because they're involved in the financing, they
14 should have been named and amended as an applicant, and we
15 didn't do that.

16 MS. OLSON: Thank you. What percentage is the
17 project?

18 MR. LEVINSON: The project -- we're hoping
19 this week or next week to request our Certificate of
20 Occupancy, survey from the City of Springfield, and then
21 immediately apply for our State licensure. So, I would say
22 we're 98-plus percent complete.

23 MS. OLSON: Thank you.

24 CHAIRMAN GALASSIE: Dr. Burden, do you still

1 have a question?

2 MR. BURDEN: Minor. I heard part of the
3 answer. I am just curious. Back in '09, April, this was
4 originally -- passed our -- had approval from us. Was at
5 that time the same number of institutions under utilized as
6 we see now? There are three. Just comment on that. Are
7 those units of a nature that they will never fill
8 utilization, or are they newer -- Illinois Presbyterian
9 Home, by name, Oak Terrace Care Center, Capitol Care
10 Center. Are any of the three now at utilization levels
11 we'd like to see?

12 MR. KNIERY: They've been consistent where
13 they are reported right now in the State Agency Report.
14 They have not -- they are older facilities. They have not
15 changed up or down in their utilization. There is one
16 facility that has not been added. Concordia Village was
17 approved by this Board just before our project, this
18 project, was approved. I can report that -- since my dad
19 is there, that that facility was opened this year and
20 it's -- it appears to be full already. So, it really seems
21 that these utilization rates have been constant throughout
22 this entire period.

23 MR. BURDEN: Your father is in a competing
24 institution?

1 MR. KNIERY: Well, this one isn't open.

2 And we can comment on Capitol, also.

3 MR. LEVINSON: We're also the operators of
4 Capitol Care Center, which would be the largest long-term
5 care provider in the City of Springfield and our census has
6 remained constant through this process. It's a specialty
7 type from what this facility is going to be, geared very
8 much towards short-term rehab. We don't anticipate it's
9 going to be a significant impact on utilization levels in
10 our building itself. So that's been a constant through the
11 process.

12 CHAIRMAN GALASSIE: Thank you.

13 Seeing no other questions, may I have a motion
14 to approve Project 12-083, Springfield Nursing and Rehab
15 Center, authorizing the establishment of a 75-bed long-term
16 care facility in Springfield, Illinois?

17 MR. DEMUZIO: Motion.

18 MS. OLSON: Second.

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

21 MR. ROATE: Motion made by Senator Demuzio,
22 seconded by Ms. Olson. Mr. Bradley?

23 MR. BRADLEY: Yes.

24 MR. ROATE: Dr. Burden?

1 MR. BURDEN: Yes.

2 MR. ROATE: Senator Demuzio?

3 MS. DEMUZIO: Yes.

4 MR. ROATE: Justice Greiman?

5 MR. GREIMAN: Yes.

6 MR. ROATE: Mr. Hayes?

7 MR. HAYES: Yes.

8 MR. ROATE: Ms. Olson?

9 MS. OLSON: Yes.

10 MR. ROATE: Mr. Penn?

11 MR. PENN: Yes.

12 MR. ROATE: Mr. Sewell?

13 MR. SEWELL: No. Unnecessary duplication.

14 MR. ROATE: Chairman Galassie?

15 CHAIRMAN GALASSIE: Yes.

16 MR. ROATE: Eight votes in the affirmative,
17 one vote in the negative.

18 CHAIRMAN GALASSIE: Motion passes.
19 Congratulations. Thank you very much.

20 Just as an aside, the Chair wants to comment.
21 It would seem to me, at some point in the future, we want
22 to address our rules. I mentioned to Frank -- I still have
23 difficulty understanding when a project comes before us for
24 approval, after it's 98 percent. So, there must be

1 something we need to address a little bit differently. I
2 share Member Sewell's concerns. The reality of it is 98
3 percent of it is complete.

4 MR. CONSTANTINO: Mr. Chairman, what we look
5 at -- we have an invalid permit sitting there. They can't
6 complete that project without a valid permit. That's why
7 they have to come back before you and get approval for the
8 project, and it's an opportunity to question the applicants
9 why they've invalidated their original permit. This gives
10 the Board the opportunity to question why you assigned your
11 permit to another party, in violation of rules, like the
12 last applicant did. That's why we do that.

13 CHAIRMAN GALASSIE: Has there ever been, in a
14 situation like that, when the permit is being revalidated
15 or validated, if you will, with stipulations or with fines
16 or some ramification for invalidating the original permit?

17 MR. CONSTANTINO: What has happened, it was
18 referred to Legal and a fine settlement was reached with
19 our Legal team; but they had to come back to get a valid
20 permit, so they can complete the project with a valid
21 permit, and the only way they can do that is with your
22 approval, with this Board's approval.

23 CHAIRMAN GALASSIE: It feels like that
24 (indicating) to me.

1 I am suggesting we take a 10-minute break -- I
2 have 11:05 -- if we can be back here in 15 minutes, 11:20.
3 Thank you very much.

4 (Recess)

5 CHAIRMAN GALASSIE: We are moving to Item No.
6 H-05 on the agenda, 12-066, Advocate Christ Medical Center,
7 and we have a few folks that represent Advocate. Good
8 morning, all. If you could take your time, get as close to
9 the microphone as you can, introduce yourself, and spell
10 your name at the same time, so we can get it in the record.
11 Thank you.

12 MR. SILVER: Good morning. I'm Marc Silver
13 (spells name).

14 MR. OURTH: Joe Ourth, Arnstein & Lehr.

15 MR. LUKHARD: Ken Lukhard (spells name),
16 President of Christ Medical Center.

17 MR. HARRISON: Robert Harrison (spells name).
18 I'm the Vice-President of Business Development.

19 MR. PAVESE: I'm Joseph Pavese (spells name),
20 Chairman of Obstetrics and Gynecology at Advocate Christ.

21 MR. MISTRY: Chintan Mistry (spells name),
22 Chairman of Emergency Medicine.

23 MR. PEKOFKSKE: Robert Pekofske (spells name),
24 V P of Finance.

1 MR. SO: Jeffrey So (spells name), Director of
2 Business Development and Community Relations.

3 MR. LYONS: Patrick Lyons (spells name),
4 Advocate, Construction.

5 (Oath given)

6 CHAIRMAN GALASSIE: Thank you.

7 Mike, Staff report, please.

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

9 The applicants are proposing the construction
10 of a 7-level patient tower, including the addition of 50
11 ICU beds, 17 OB beds, and 27 NICU beds. The cost of this
12 project is approximately \$300 million. The anticipated
13 project completion date is July 31st, 2013 -- 19. The
14 project was deferred from the October 30-31st, 2012 State
15 Board meeting. The applicants filed a Type B modification,
16 reducing the cost of the project by approximately \$46
17 million.

18 Thank you, Mr. Chairman.

19 CHAIRMAN GALASSIE: Thank you, Michael.

20 I'm assuming all of you are not going to be
21 addressing the Board; but whoever is going to start, please
22 do.

23 MR. LUKHARD: Mr. Chairman, thank you. Let me
24 very quickly outline, just so you know a little bit about

1 our institution. We're a 694-bed teaching/research
2 institution, and in the last several years Christ has won a
3 number of national awards, including U S News and World
4 Report's 100 top hospitals and several other really
5 significant national awards, based on quality of care there
6 at our campus. We are the only, as you know, Level I
7 trauma center in the south, serving the entire south,
8 southwest side of the city and surrounding neighborhoods,
9 and the bottom line is that we are out of space. We've
10 been out of space now for many years.

11 I've been there seven years as the President
12 and we continually are on bypass. In 2011, we were on
13 bypass over 1,100 hours, which means the ED is shut for
14 patients. That translates to 3 to 4,000 admissions a year
15 that are unable to access our hospital, oftentimes in
16 life-threatening conditions.

17 We've the highest occupancy rate of any
18 hospital in the City of Chicago. We're the largest heart
19 program in the state, the largest stroke program. We are
20 second in admissions only to Northwestern, and we are doing
21 that with occupancy that exceeds 80 percent. In our ICU's,
22 our occupancy is 98 percent.

23 Part of the problem of why we go on bypass so
24 often is that we have just a total lack of ICU beds, which

1 this project speaks to. In 2011, we provided \$4.9 million
2 worth of charity care, a 44 percent increase over 2010. As
3 you know, last year you approved our outpatient pavilion.
4 That's being built as we speak and is really going to be a
5 huge patient satisfier to those we serve in our
6 communities.

7 The project today focuses on three key areas:
8 ICU, adult ICU, OB, obstetric and neonatal service. And
9 this project, as I mentioned, is really critical to serve
10 the growing demand of services in our community and
11 surrounding communities for our hospital.

12 I could spend a lot of time, which I'm not
13 going to, talking about other wonderful aspects of our
14 healthcare ministry, but the fact is, your team found only
15 one concern in our report. Can I speak to that real
16 quickly?

17 CHAIRMAN GALASSIE: Please do.

18 MR. LUKHARD: Thank you. We exceed the State
19 guideline for square footage in our Phase 1 recovery area.
20 Briefly to describe that -- and Dr. Pavese could speak to
21 that in detail -- we have four surgical delivery rooms for
22 C-sections and high-risk deliveries. Those four rooms
23 support operating rooms in need. So, the recovery rooms
24 support the operating rooms, and we need space to, A, be

1 able to accommodate multiple clinical teams for high risk
2 moms and babies. When moms and babies are at risk, not
3 just one team of physicians are in there. We need room for
4 medical nursing and EMT students and special equipment.
5 These rooms are also private, which will improve infection
6 control, reduce infection rates in that area, and
7 promote -- that additional space will promote staff
8 efficiency.

9 The bottom line is, if you take the square
10 footage of these two areas, the recovery space and the
11 surgical suites together, they are under 4,000 square feet
12 less than the State guidelines allows. So, if you combine
13 them, we're actually under State guidelines.

14 So, in summary, that is a quick review of the
15 project. I'd like to thank your staff for the great job
16 they've done in helping us prepare this application.

17 CHAIRMAN GALASSIE: Thank you, sir. I
18 appreciate that.

19 I'm going to open it up to questions from the
20 Board.

21 MR. GREIMAN: I have a question. You made a
22 great case -- let me say, first, that your charitable work
23 is very impressive. It's probably the highest I've seen
24 around. That said, you made a case for a lot of important

1 changes. How come it takes until 2019 to finish the
2 project?

3 MR. LUKHARD: That's a great question.

4 Really, the tower, the bed tower itself, will be done by
5 early 2015. That will then allow us to go back and create
6 additional space inside the existing building for the new
7 ICU's and also an additional twelve post-partum beds. So,
8 if you string that all out, it really adds then to -- it
9 adds an additional couple years. The main tower itself
10 will be done by early 2015.

11 MR. GREIMAN: So most of your project will be
12 completed by then, in these two and a half years?

13 MR. LUKHARD: Yes.

14 MR. GREIMAN: And the rest will be completed
15 as time goes on?

16 MR. LUKHARD: Yes, and those are timing moves,
17 and a lot will happen as space becomes available.

18 MR. GREIMAN: Okay.

19 MR. LUKHARD: Good question. Thank you, sir.

20 CHAIRMAN GALASSIE: Dr. Burden?

21 MR. BURDEN: I would like to just comment
22 about -- really not directly to what you're here for, but
23 it's interesting to me. When you recognize this great
24 institution, 25,000 admissions a year, and you also heard,

1 probably, the prior application where we have an inner
2 city -- two inner city institutions, medical institutions
3 that are merging, and have a list of Medicare and
4 Medicaid -- well over yours, obviously -- safety net area.
5 Do you envision the future of your institution, long range,
6 even becoming larger, all the way as we face significant
7 challenges coming up? As a retired physician, I'm happy to
8 be retired in one respect, but I listen to the problems
9 that are going on. You're aware, much more aware, of them
10 than I. Do we see something happening to our inner city
11 folks that is going to be a larger problem, rather than
12 what you envision for yourself, encompassing the issues
13 that are facing the big urban areas? Not just Chicago, but
14 this is nationwide.

15 MR. LUKHARD: Yeah, that's a phenomenal
16 question, and can I take just a moment to answer that?

17 CHAIRMAN GALASSIE: Please.

18 MR. LUKHARD: So, really, I think there's two
19 or three things that are worth noting. One is that what
20 really separates Christ from the other hospitals in the
21 southland is that we're the only tertiary quality provider
22 south of 55. So, we're a lot different than the
23 surrounding hospitals around us, because we are treating
24 the truly sickest of the sick. We're now getting

1 transplant patients sent from academic centers downtown.
2 Our team is really skilled, and we're doing a tremendous
3 job.

4 I think where the hospitals are going to
5 struggle tremendously in the future, sir, is that as
6 reimbursement continues to be cut, I think that the
7 stand-alone hospital will struggle. Holy Cross has
8 requested -- and I'm a fan of Wayne Lerner's. His request
9 to join a system is very -- is the trend, and so most
10 stand-alone hospitals are going to join systems to allow
11 them to survive economically in the years ahead. So, I
12 think as reimbursement continues to shrink -- as you know,
13 Medicare is cutting our reimbursement two percent a year,
14 payors are cutting reimbursement. It's just not an easy
15 time for hospitals. So, it will be a challenge, I think,
16 for all of our careers.

17 MR. BURDEN: You mentioned the transplant
18 team. They were first-rate, notwithstanding the fact that
19 a nephrologist was a hot looking chick. I remember her.
20 She would not like to have me say that about her, but I was
21 very impressed with that little girl.

22 (Laughter)

23 CHAIRMAN GALASSIE: Let the record show that's
24 a technical term.

1 MR. LUKHARD: If I could just say, sir,
2 Thursday night I attended -- I'll just tell this real
3 quickly. I attended a Christmas party for all of our
4 living transplant patients. We had 125 patients in a
5 dining room, with their spouses. If you could have heard
6 the stories told -- and a lot of those folks would not have
7 made it to another institution, would not have been
8 alive -- that the work that our teams are doing clinically
9 are utterly astounding, and Dr. Silver and the other
10 physicians can speak to that; but it's remarkable.

11 CHAIRMAN GALASSIE: Chilling and wonderful
12 story.

13 Member Sewell?

14 MR. SEWELL: This, again, is not directly
15 relevant, following in the spirit of Dr. Burden.

16 MS. OLSON: Oh, no.

17 MR. LUKHARD: I can handle anything after that
18 question.

19 MR. SEWELL: This Level I trauma center, you
20 are the trauma provider as far east as Lake?

21 MR. LUKHARD: Yes.

22 MR. SEWELL: And it probably resulted in your
23 having to do something with these intensive care cases.

24 MR. LUKHARD: Exactly, sir.

1 MR. SEWELL: Is the State going to do anything
2 with respect to providing support? I think -- years ago, I
3 think the State provided support to Level I trauma centers.

4 MR. LUKHARD: The reason that most hospitals
5 stopped doing Level I trauma is that, A, it's very
6 expensive; two, you lose money on it; and, three, it's hard
7 to keep enough sub-specialists in-house to provide the
8 care. Christ is very fortunate that among our 1,200
9 doctors, we have doctors of great skill and expertise that
10 are willing to commit themselves to that kind of level of
11 care. You'll see that when hospitals pursue Level I, the
12 doctors revolt and don't want to do it, because it is a
13 huge demand upon their time and their lives.

14 So, to answer your question, sir, I think that
15 Christ and Advocate is committed. We have and operate most
16 of the trauma centers in the entire city, as you know.
17 It's part of our mission, and no matter what it costs us,
18 we continue to do it and do it with great passion and
19 skill.

20 CHAIRMAN GALASSIE: David, do you have a
21 question? And then Member Olson.

22 MR. CARVALHO: I do, although I can't keep my
23 question in the same vein as Dr. Burden.

24 CHAIRMAN GALASSIE: Thank you.

1 MR. CARVALHO: One element of the CON process
2 is identifying alternatives considered and then focusing in
3 on the one of the application. One of the alternatives
4 that you identified was the construction of a new hospital
5 in the Tinley/Orland Park area, and that reminded me that
6 when that project was before the Board about seven years
7 ago -- in fact, part of the explanation for that project
8 was the tightness of the demand and the utilization of
9 resources at the Oak Lawn facility; and so, in some
10 respects, it's not surprising to see that since that
11 project was not approved, that down the road the need to
12 deal with the tightness of services at Oak Lawn has led to
13 this application.

14 But the other thing that was talked about at
15 the time -- and it occurred to me, because you've
16 identified -- yes, you're right, Joe. You've identified
17 the Service Area of this hospital as being the south and
18 southwest suburbs, and you do have a facility in the south
19 suburbs --

20 MR. LUKHARD: We do.

21 MR. CARVALHO: In Hazel Crest. If you look at
22 the State profiles for last year, Oak Lawn showed a
23 utilization of about 85 percent, and South Suburban showed
24 a utilization of about 55 percent. So, clearly the

1 high-end tertiary, intensive care, trauma-type services
2 that you provide at Oak Lawn can only be provided at Oak
3 Lawn. But have you considered trying to offload some of
4 the lower level services -- that are also provided at Oak
5 Lawn -- to rationalize the distribution of services within
6 the brick and mortar complement of facilities that you own,
7 as, for example, South Suburban.

8 MR. LUKHARD: That's a tremendous question.
9 I'd like to answer it by saying that part of my
10 responsibility with Advocate is -- I used to hold the title
11 of Market President, and I am responsible for the south
12 market. One of the things I do is lead a team that looks
13 at how we can decant the campus of Christ and send the
14 lower level care cases to Trinity and to South Suburban.
15 So, we do that currently. We meet monthly to keep pursuing
16 that. We've helped South Sub become a certified stroke
17 center. We've helped Trinity become a certified stroke
18 center. They now do invasive cardiology and services they
19 did not offer before. So, what we're doing is really using
20 our tertiary expertise at Christ, helping those other
21 hospitals increase their capability; send patients that
22 don't need to be at Christ to those campuses; and try to
23 save the high-end care for the beds at Christ. Physicians
24 can still admit where they choose, and some doctors will

1 always choose Christ, even though there's availability at
2 other hospitals, but the fact is we're actively looking to
3 really coordinate care for this entire south region, per
4 exactly your suggestion, and we're doing it.

5 CHAIRMAN GALASSIE: Thank you.

6 Member Olson?

7 MS. OLSON: My question is actually quite
8 simple as compared to my esteemed colleagues here. Your
9 track record of treating uninsured and under insured is
10 fabulous. Something is bugging me. Why does it say you're
11 under targeted utilization for all of these areas -- OB,
12 the NICU, the ICU. I don't understand, because everywhere
13 else in the report it says you're at or over utilization.
14 What's up with Table One -- it's not working for me -- in
15 the State Agency Report?

16 MR. CONSTANTINO: As compared to the State
17 standards, Kathy. We compare it to the State standards,
18 the State standard in the second to the last column on your
19 right. Their current "Utilization Proposed Beds", the
20 number of beds they're proposing based upon their 2011
21 average daily census, is 79 percent. This is for med/surg.
22 Our standard is 88 percent. They don't meet that standard.
23 That's all we're trying to say there.

24 MS. OLSON: Because it seems like further in

1 the report, on other tables, it does say they do meet the
2 standards. I guess I'm trying to reconcile. But that's
3 okay.

4 MR. LUKHARD: Let me just quickly explain a
5 few things. We run at capacity most days. The reason we
6 do is 60 percent of our beds are semi-private. If you have
7 a patient in a semi-private room that's a male, you cannot
8 admit a female. If the male patient has an infectious
9 disease, you cannot admit another male to that room. So,
10 given our beds and our complement of beds, we run close to
11 full every day, and many days we are literally full and
12 can't accept any admissions, which is why we turn away 3 to
13 4,000 admissions every year. It's really a chronic
14 problem, and for the patients that are really sick and need
15 to get there, time is life, and the need to add additional
16 ICU beds on our campus is really critical because of that
17 nature. But we do run a very, very high level and if you
18 look at the Crains Report, we have the highest occupancy of
19 any hospital in the city. Nobody is really even a close
20 second, really.

21 MS. OLSON: Thank you.

22 CHAIRMAN GALASSIE: Interesting. Obviously
23 it's not south, because -- what direction is the campus
24 growing?

1 MR. LUKHARD: You mean, in terms of its --

2 CHAIRMAN GALASSIE: The campus itself. Is it
3 growing east? Are you buying land east?

4 MR. LUKHARD: No, we're not buying any land.
5 We're just building up. We're tearing down and building
6 up. So in this case, we are tearing down a garage and
7 building a tower in its place.

8 CHAIRMAN GALASSIE: I hadn't been there in 30
9 years, having had three daughters born there. I went there
10 recently and was blown away by what's occurring in the
11 facilities.

12 MR. LUKHARD: Yeah, and it's changing
13 dramatically.

14 CHAIRMAN GALASSIE: Truly remarkable.

15 MR. LUKHARD: Thank you, sir.

16 CHAIRMAN GALASSIE: Member Penn?

17 MR. PENN: If you are serving patients from
18 Indiana, do you know what your percentage of your patient
19 population comes from Indiana?

20 MR. LUKHARD: I don't personally know that.

21 MR. PEKOFKSKE: We do serve patients from
22 Indiana. It's only one or two percent, though.

23 CHAIRMAN GALASSIE: Any other questions?

24 (Pause)

1 CHAIRMAN GALASSIE: Hearing none, may I have a
2 motion to approve Project 12-066, Advocate Christ Medical
3 Center, authorizing the construction of a patient tower on
4 its hospital campus in Oak Lawn, Illinois?

5 MR. SEWELL: So moved.

6 MR. GREIMAN: Second.

7 CHAIRMAN GALASSIE: Moved and seconded. Roll
8 call, please.

9 MR. ROATE: Motion paid by Mr. Sewell,
10 seconded by Justice Greiman.

11 Mr. Bradley?

12 MR. BRADLEY: Yes.

13 MR. ROATE: Dr. Burden?

14 MR. BURDEN: Yes.

15 MR. ROATE: Senator Demuzio?

16 MS. DEMUZIO: Yes.

17 MR. ROATE: Justice Greiman?

18 MR. GREIMAN: Yes.

19 MR. ROATE: Mr. Hayes?

20 MR. HAYES: Yes.

21 MR. ROATE: Ms. Olson?

22 MS. OLSON: Yes.

23 MR. ROATE: Mr. Penn?

24 MR. PENN: Yes.

1 MR. ROATE: Mr. Sewell?

2 MR. SEWELL: Yes.

3 MR. ROATE: Chairman Galassie?

4 CHAIRMAN GALASSIE: Yes.

5 MR. ROATE: That's nine votes in the
6 affirmative.

7 CHAIRMAN GALASSIE: Motion passes.
8 Congratulations.

9 MR. LUKHARD: Mr. Chairman, members of the
10 Board, thank you so much.

11 CHAIRMAN GALASSIE: Item 12-078, Adventist
12 Cancer Institute, has been deferred.

13 Moving on to 12-080, Memorial Medical Center.
14 We have no public comment requests. Representatives from
15 Memorial, again, if you would please come up and make
16 yourself comfortable. Introduce yourself by spelling your
17 name in the mic nearby, and we'll get you sworn in.

18 MR. JOHNSON: Mitch Johnson (spells name).

19 MS. DOUGLAS: Becky Douglas (spells name).

20 (Oath given)

21 CHAIRMAN GALASSIE: Thank you.

22 Staff report, please.

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

24 The applicants are proposing to modernize and

1 expand services at its existing acute care hospital. The
2 cost of the project is approximately \$122 million. The
3 anticipated project completion date is December 31st, 2016.

4 Thank you, Mr. Chairman.

5 CHAIRMAN GALASSIE: Thanks, Mike.

6 Comments for the Board? Mr. Johnson?

7 MR. JOHNSON: Yes, thank you. In the interest
8 of time, we would just be happy to answer questions.

9 CHAIRMAN GALASSIE: Thank you very much.

10 I would like to open this project up for
11 questions by the Board.

12 MR. SEWELL: Mr. Chairman?

13 CHAIRMAN GALASSIE: Yes, sir, Mr. Sewell.

14 MR. SEWELL: I'd like to hear your comments on
15 this State standard that's not met, the reasonableness of
16 project costs.

17 MR. JOHNSON: Yes. Thank you. The only
18 negative finding was the construction costs per square
19 foot. It was higher than the State standard. Although the
20 cost per square foot does appear high, the proposed project
21 will allow us to reduce the overall project costs and
22 efficiency once the project is complete. The cost per
23 square foot is higher than normal due to complexities
24 associated with building on top of and immediately adjacent

1 to the existing E Building, while continuing to keep the E
2 Building open throughout the construction period. Existing
3 E building services include our main surgery and two
4 medical/surgical nursing units. This will require
5 extraordinary construction accommodations, phasing, and
6 costs. However, the total cost of the proposed project is
7 only 122 million versus \$200 million for a free-standing
8 tower to accomplish the same objectives.

9 Also, building in this location will
10 significantly reduce travel distances, time, and
11 operational expenses, once the project is complete. To put
12 this in perspective, our construction costs are \$429 per
13 gross square foot versus the State standard of \$400. When
14 you multiply the difference by the gross square feet
15 involved, this equates to total extraordinary costs of just
16 under \$3 million, or 2.4 percent of the total \$122 million
17 project costs.

18 We feel that this project represents the most
19 prudent approach to achieving all private medical/surgical
20 rooms and expanded surgical capacity for our community. I
21 can elaborate, or I'd be happy to answer other questions.

22 Thank you.

23 CHAIRMAN GALASSIE: Thank you.

24 Other questions?

1 (Pause)

2 CHAIRMAN GALASSIE: Hearing none, may I have
3 a motion to approve Project 12-080, Memorial Medical
4 Center, authorizing a major modernization/expansion project
5 in Springfield, Illinois?

6 MR. BRADLEY: So moved.

7 MR. SEWELL: Second.

8 CHAIRMAN GALASSIE: Moved and seconded. Roll
9 call.

10 MR. ROATE: Moved by Mr. Bradley seconded by
11 Mr. Sewell.

12 Mr. Bradley?

13 MR. BRADLEY: Yes.

14 MR. ROATE: Dr. Burden?

15 MR. BURDEN: Yes.

16 MR. ROATE: Senator Demuzio?

17 MS. DEMUZIO: Yes.

18 MR. ROATE: Justice Greiman?

19 MR. GREIMAN: Yes.

20 MR. ROATE: Mr. Hayes?

21 MR. HAYES: Yes.

22 MR. ROATE: Ms. Olson?

23 MS. OLSON: Yes.

24 MR. ROATE: Mr. Penn?

1 MR. PENN: Yes.

2 MR. ROATE: Mr. Sewell?

3 MR. SEWELL: Yes.

4 MR. ROATE: Chairman Galassie?

5 CHAIRMAN GALASSIE: Yes.

6 MR. ROATE: Nine votes in the affirmative.

7 CHAIRMAN GALASSIE: Motion passes.

8 Congratulations. Good luck to you.

9 (Pause)

10 CHAIRMAN GALASSIE: Next item is Fresenius

11 Medical Care of Lockport. We have one request for public

12 comment. You do not have to be sworn in, but if you would

13 introduce yourself for the record, and recall that we have

14 a two-minute limit for presentation.

15 Thank you.

16 MR. CHAWLA: Good morning, Chairman and

17 members of the Board. I'm Dr. Bhuvan Chawla. I'm here to

18 urge the Board to reject this application.

19 This application is misleading as it is

20 presented as a replacement to Project 09-039, which had

21 been approved by the Board in December of 2009. At the

22 time the Board seldom rejected any dialysis applications.

23 Subsequently, the Board has updated its scrutiny of

24 dialysis projects and has rejected several of these

1 projects. That initial project was eventually abandoned to
2 be replaced by Project 11-022, which was then rejected by
3 the Board in December of 2011 on the grounds of
4 non-conformance with need, unnecessary duplication,
5 maldistribution, and excessive size. Seven months later,
6 Fresenius has essentially resubmitted the same application,
7 disguised as a replacement for Project 09-039 and not for
8 11-022. This is misleading.

9 The Board apparently did not receive my letter
10 of opposition, but did receive my response to the SAR. My
11 letter of opposition was submitted on November 30th, which
12 was the deadline listed on the web site, and I have copies
13 of that from the web site and my letters here, if the Board
14 wants to see them.

15 This application incorrectly seeks to exclude
16 Fresenius Mokena, based on the 30-minute and 48-second
17 drive from the proposed project. Fresenius Mokena operates
18 at 58 percent utilization and is only 18 minutes away from
19 the 40 proposed patients from Homer Glen. This application
20 also incorrectly dismisses Sun Health on the grounds that
21 we operate five shifts.

22 MR. MORADO: Thirty seconds.

23 MR. CHAWLA: The Board needs to know that Sun
24 Health always operated six shifts until recently, when we

1 suspended one shift because of the drop in census because
2 of duplication and maldistribution.

3 The Board rejected this application in
4 December 2011, and I would urge the Board to reject it
5 again. Thank you.

6 CHAIRMAN GALASSIE: Thank you, Doctor. There
7 was some confusion in updating our web site. Thus, if
8 members would like to see a copy of the letter, we're happy
9 to get it to you.

10 MR. CONSTANTINO: That letter was sent to you,
11 Mr. Chairman.

12 CHAIRMAN GALASSIE: Oh, it was? I apologize.

13 MR. CONSTANTINO: I have copies here. If
14 someone wants to look at it, I'd be happy to distribute it.

15 CHAIRMAN GALASSIE: Sure. Go ahead. I'll
16 move forward while you're doing that.

17 Representatives from Fresenius Medical Care
18 Lockport?

19 (Pause)

20 CHAIRMAN GALASSIE: Project 12-055. Good
21 morning, ladies. You know the drill.

22 MS. MULDOON: I'm Coleen Muldoon. I'm the
23 Regional Vice-President of Fresenius; to my right, Lori
24 Wright, CON; to my left social worker, Christine Yazunbek;

1 and Clare Ranalli, our CON counsel.

2 I quickly want to address -- I want to thank
3 everyone for considering our project again. You may recall
4 that we previously brought this project before you for a
5 facility in Lockport. The first was approved, but we lost
6 our site due to landlord issues. Since then, our
7 projects in the area -- other projects in the area have
8 been approved. It is important that you know that in
9 filing repeated requests, we mean no disrespect to the
10 previous decisions. There is no question that for us it
11 takes time, effort, and money to come before you on CON
12 applications, and that -- and that we do not do this
13 lightly on projects such as this. However, we do believe
14 the unique circumstances in Lockport do merit your
15 consideration, and we are asking for your patience in
16 listening to us as we advocate for the project once again.

17 I'm going to turn this over to Christine, who
18 is our social worker for the Orland Park and Mokena clinics
19 and lives in the area.

20 MS. YAZUNBEK: Good morning. As Coleen said,
21 I'm the social worker at the Orland and Mokena dialysis
22 clinic. I also live in the Orland Park area and spend a
23 great deal of time traveling to the Lockport area for my
24 daily errands.

1 My job is to help patients with their issues,
2 such as transportation, shift choice, dealing with
3 hardships of dialysis. My patients tell me on a regular
4 basis that they wish there was a dialysis center in
5 Lockport. I have patients who live and work in Lockport,
6 and it's a burden for them to have to travel to Orland and
7 Mokena. Lockport is a small town that has experienced a
8 housing boom during the -- I'm sorry -- a housing explosion
9 during the housing boom. The roads in this town are
10 two-lane roads, and they're not meant to handle the traffic
11 that is there. To the west, you have the railroad tracks,
12 followed by a long bridge over a canal. It's very
13 congested, and if there is an accident, you're stuck. To
14 the east is two-lane 159th Street that goes to four-lane,
15 which is in a large shopping area. I realize that you use
16 Map Quest and you did a travel time, but I don't agree with
17 the travel times. I've been on the road and been stuck in
18 this traffic.

19 Another major issue is that patients living in
20 Homer Glen and Lockport who need public transportation, the
21 community services and the public transportation, cannot
22 get it to Orland and Mokena. This means they either have
23 to rely on family or pay privately. There are 59 patients
24 identified in Homer Glen and Lockport that will not be able

1 to use the services to get to Orland Park, Palos Park or
2 Mokena. However, Lockport Township will transport
3 patients to the Lockport site.

4 Finally, it isn't easy to utilize other
5 existing clinics, as it might seem. The wait time for area
6 patients who want to go to more local facilities is long.
7 As an example, patients who have tried to transfer to
8 Silver Cross New Lenox have waited up to a year.

9 Please help me help my patients and approve
10 the Lockport clinic. Thank you for your time.

11 MS. WRIGHT: I've got a map here of the
12 Lockport site, and it's right here in the middle
13 (indicating). As you can see in the perimeter are clinics
14 that are either highly utilized in red and or under
15 utilized in yellow, and then right down the middle here
16 you've got kind of a natural dividing line, which Christine
17 spoke about, the canal, Des Plaines River and railroad
18 tracks. There's only one bridge in Lockport that crosses
19 that. You can see that most of our patients do live in
20 Lockport, Homer Glen. There's some in Lemont. They're
21 east of the river. So, more than likely, they're going to
22 travel east over to the Palos Park, Orland, Mokena area.
23 That means, again, heavily-congested, two-lane 159th
24 Street. Once they reach Palos Park and the Orland area,

1 you do that in this case?

2 MR. RANALLI: I'm sorry. Is the question
3 whether you require --

4 MR. GREIMAN: Whether you would advise your
5 physicians that you would accept charity.

6 MS. RANALLI: Oh, yes, absolutely, and as
7 we've indicated, the credentialing process that physicians
8 have to go through to be able to admit patients to the
9 Fresenius medical clinics requires that they accept all
10 patients, regardless of ability to pay.

11 MR. GREIMAN: Well, I understand, except, you
12 know, the problem is that people don't just walk in to your
13 place. They are sent by the doctor, and so the doctor has
14 to know that, and you have to advise the doctors that send
15 people. You wouldn't object if that's part of your order?

16 MS. RANALLI: They are advised that is our
17 requirement, that physicians accept all patients,
18 regardless of ability to pay. So that is part of our
19 process and our relationship with the physicians that we
20 work with.

21 MR. GREIMAN: And so you would agree that to
22 be part of the order?

23 MS. RANALLI: Yes, and we've agreed to that in
24 the past.

1 MR. GREIMAN: Because at this point -- I know
2 you have. That's why I'm raising it. At this point, you
3 guys have about 60 percent of the stations in Illinois. So
4 you're pretty critical -- what you do is pretty critical.

5 MS. RANALLI: Yes, absolutely; and we do
6 provide a list of all of our clinics and the percentage of
7 Medicaid, as well, and we have a very high level of
8 Medicaid patients in many of our clinics.

9 MR. GREIMAN: Even though I told one of you a
10 few months ago that if you got over 50 percent, I wouldn't
11 vote for you, I've got to probably change my mind.

12 MS. RANALLI: Thank you.

13 MR. CONSTANTINO: Mr. Chairman?

14 CHAIRMAN GALASSIE: Yes.

15 MR. CONSTANTINO: We had a comment on this
16 State Agency Report we have to take action on, 12-055. It
17 was distributed just a few minutes ago. Dr. --

18 CHAIRMAN GALASSIE: Right. We have to have a
19 motion to get it in the record?

20 MR. CONSTANTINO: Right.

21 CHAIRMAN GALASSIE: I need a motion to accept
22 the letter from Dr. Chawla, dated November 30, 2012, into
23 the record.

24 MR. BURDEN: So moved.

1 MS. OLSON: Second.

2 CHAIRMAN GALASSIE: Moved and seconded.

3 MR. PENN: Can I take a minute to read this
4 before you vote?

5 CHAIRMAN GALASSIE: We're just accepting it
6 into the record.

7 CHAIRMAN GALASSIE: All in favor.

8 ("Ayes" heard)

9 CHAIRMAN GALASSIE: Opposed?

10 (No response)

11 CHAIRMAN GALASSIE: Motion carries.

12 Are there any other questions from members,
13 while some folks are reading the letter?

14 Member Hayes and then Member Penn.

15 MR. HAYES: In this -- you mentioned there's
16 been -- in the public comment period, there's been a
17 mention that there was Permit 11-022 in May of 2011, and I
18 kind of remember that, and that was -- of course, that was
19 rejected by the Board. Can you comment on what is the
20 difference between this application, and now you're coming
21 back again in 2012 with -- obviously, it's a very similar
22 location. Why don't you comment on that?

23 MS. WRIGHT: As you recall, the first
24 application in 2009 was approved, and the landlord could

1 not go forward with the project. So, we withdrew the
2 application, reapplied to a site just across the street.
3 It was denied last year. We do have, as Christine said,
4 patients asking when Lockport clinic is going to be up.
5 The town of Lockport was hoping for this to come to their
6 town. So, in response to that, we reapplied, even though
7 it is similar situation.

8 MR. HAYES: So this is in the same location
9 with the same general project, is that correct, as in 2011?

10 MS. WRIGHT: Yes.

11 MS. RANALLI: And that is why, Mr. Hayes, to
12 your point -- Ms. Muldoon, when she introduced the
13 project -- clearly, we mean no disrespect in coming back in
14 front of you again. We just have our patients telling
15 us -- telling Christine again and again about the
16 transportation issues unique to Lockport because of the
17 bridge and the railroad tracks. That's what we're
18 responding to, is those issues that were raised. But we
19 certainly mean no disrespect in coming before you again.
20 We're just really advocating for the project.

21 CHAIRMAN GALASSIE: Dr. Burden?

22 MR. BURDEN: It's a conundrum for me. I wish
23 to spend my entire free time studying your industry. It
24 looks like it's appearing -- this data -- on every

1 application that makes one lean towards accepting every
2 application. Yet, I certainly am -- have read Dr. Chawla.
3 He's been an advocate for not allowing or not supporting
4 it, and yet I see also your statement. There's 47 stations
5 in excess, but, apparently, they feel -- the State
6 Agency -- I don't understand it, how it cannot reduce --
7 create an unnecessary duplication of service. This is
8 between need and want. The issue is becoming very tedious
9 and difficult for me. I understand what was said by the
10 social worker. I visited some of these sites. It is
11 sometimes inconvenient, and I would expect it to remain
12 always such. I don't know how to evaluate your attitude.
13 I understand it, but I have trouble evaluating. Does
14 everybody who has chronic renal disease deserve to have an
15 opportunity to walk or be close to where the -- are we --
16 is this becoming a standard, like Walgreens and other areas
17 that serve people? Put one up on every corner? I
18 understand why you're here. I appreciate what you're
19 saying, but, by the same token, there's an excess of beds.
20 We have an individual nephrologist who is not part of this
21 huge megalopolis, FMC or DaVita, who has an opportunity to
22 explain his reasons, and they're valid. He has under
23 utilization. He's in the community.
24 I have to listen to both sides. It's hard for

1 me as an individual physician, practicing -- I never had
2 this problem occurring in my practice, but I hear it all
3 the time here. I don't know how -- other Board members can
4 solve it as they see fit, but I find need versus want.
5 That's constantly coming up on this. I'm just saying I
6 have to look at what's in front of me. I hear what you're
7 saying, but what's in front of me says there's already an
8 excess of stations.

9 MS. MULDOON: Can I make a quick comment?

10 CHAIRMAN GALASSIE: Sure. Please.

11 MS. MULDOON: Because in the area where the
12 physician does practice at and has comments against this
13 report, there are multiple facilities that do surround him
14 that are 80 to 90 percent utilized. We practice in that
15 area, and we really struggle trying to get our patients in.
16 I cover over 50 dialysis units in this area, and my average
17 utilization in those dialysis units is 80 percent. I deal
18 daily with patients who can't get into dialysis. I know
19 the 30-minute rule, but if you try to drive 30 minutes and
20 a patient driving 30 minutes one way, it's an hour a day,
21 three times a week. That is really difficult for these
22 patients, and the Lockport -- the location of that
23 facility -- it is very, very difficult for those patient to
24 get into that area, as Christine has commented on, and we

1 would not be before you on this project if we didn't think
2 it was a good project. I mean, there is time and money on
3 our side and, we know, time on your side to look at these
4 projects, and we respect that, but we do feel strongly that
5 Lockport -- there's a dialysis facility required in this
6 area, and that's why we're before you today.

7 MR. BURDEN: I hear what you say, but I can't
8 help but say perhaps the rules and regs that the State
9 Agency provides should be readjusted. Your comments are
10 understood, but we have in front of us data that says
11 something to the contrary. I personally understand what
12 you're saying. You have any number of patients who can't
13 and don't have the opportunity to travel distances that
14 appear to be arduous. I appreciate that, but I don't know
15 whether I can accept it as -- again, it's need versus want.
16 I mean, I don't understand how we can handle problems like
17 this and be fair to all parties concerned. You understand
18 my point. I mean, I don't know. The other Board members
19 may disagree.

20 MS. MULDOON: No, it's understood.

21 CHAIRMAN GALASSIE: Member Penn, did you have
22 a question?

23 MR. PENN: Dr. Burden asked the first part.
24 And I guess -- I don't know if -- this goes probably first

1 to Mike. I don't know if we have a rule or a regulation to
2 determine the amount of time a person be given to do a
3 project based on the cost of the project. I look at these
4 applications. There's hundreds of millions of dollars of
5 work, new towers and so forth, being built, and for this
6 project at \$3.3 million, it's two-thirds the amount of time
7 it takes to build a project for 300 million. That's one
8 percent of this project, but it's almost two-thirds the
9 amount of time to build it. Do we have a rule or a
10 regulation, a rule of thumb?

11 MR. CONSTANTINO: No, we don't.

12 MR. PENN: So they put down the amount and
13 put down how much time they want to build the project?

14 MR. CONSTANTINO: Yes.

15 MR. PENN: Really?

16 MR. CONSTANTINO: This question came up at the
17 last Board meeting, and we looked at the past five years of
18 data in which projects were approved by the Board and
19 completed, and, approximately, it took them 16 months to --
20 from the date you approved it to the time it was completed.
21 Some of this is probably due to my instructing them to make
22 sure they build in enough time to take into consideration
23 the IDPH survey. They're extremely backed up and have
24 taken additional time to get out and survey their facility.

1 So, I've taken upon myself to tell the applicants to make
2 sure they give themselves enough time, so they don't have
3 to come back for a permit renewal or be in -- invalidate
4 the permit and not get it done in time.

5 MR. PENN: So you work with them on the
6 construction timeline?

7 MR. CONSTANTINO: Yes. I tell them, "you need
8 to make sure you build in enough time to consider all the
9 ramifications that could happen. One of them is the IDPH
10 survey that could require additional time."

11 MR. PENN: I just want to make sure we're
12 being fair to the people taking on these bigger projects,
13 \$300 million projects, and they're using, you know, just a
14 little over three, four years. Some of these projects are
15 two years and they're one percent of the total cost.

16 MR. CONSTANTINO: Yeah.

17 MR. PENN: Okay.

18 MR. CONSTANTINO: But like I said, on average
19 for all ESRD projects that you've approved and have been
20 completed, it's taken them from start to finish about 16
21 months.

22 CHAIRMAN GALASSIE: Any other questions?
23 Member Hayes?

24 MR. HAYES: You know, in the State Agency

1 Report, it mentions -- one of the reasons why it seems to
2 think that this facility may be needed is that there's one
3 station for every 7,611 residents within 30 minutes of the
4 zip code area and the State's average is 3,347 residents,
5 and that would seem to be a big statement in the State
6 Agency Report, as I read it here. Is that part of our
7 standards for the State?

8 MR. CONSTANTINO: Yes. It's under
9 "Unnecessary Duplication, Maldistribution".

10 MR. HAYES: Well, in this case it's opposite,
11 that basically that there is a need for more stations
12 because of this average residents -- because of the average
13 residents. It's almost twice as much.

14 MR. CONSTANTINO: That's correct, within that
15 30-minute time frame; yes, that's correct, John.

16 MR. HAYES: I haven't seen this on other
17 projects particularly, especially when we're looking at a
18 very population dense area here.

19 MR. CONSTANTINO: It has to be one and a half
20 times the State average. That ratio has to be one and a
21 half times the State average.

22 MR. HAYES: Okay.

23 MR. CONSTANTINO: And that's why you don't --
24 even though we report it in the report, most of the times

1 they don't -- the applicants are unable to do that, one and
2 a half times the State average. In this case, it's over
3 two times the State average.

4 MR. HAYES: Okay. Thank you.

5 CHAIRMAN GALASSIE: Hearing no other
6 questions, I'm going to move us forward. May I have a
7 motion to approve project 12-055, Fresenius Medical Care
8 Lockport, authorizing the establishment of a 12-station
9 ESRD facility, Lockport, Illinois.

10 MS. DEMUZIO: Motion.

11 MS. OLSON: Second.

12 CHAIRMAN GALASSIE: Motion and seconded.

13 **Q MR. ROATE: Motion made by Senator**
14 **Demuzio, seconded by Ms. Olson.**

15 **Mr. Bradley?**

16 MR. BRADLEY: Yes.

17 MR. ROATE: Dr. Burden?

18 MR. BURDEN: I'm going to vote no, based on
19 the excess stations and my prior comments.

20 MR. ROATE: Senator Demuzio?

21 MS. DEMUZIO: Yes.

22 MR. ROATE: Justice Greiman?

23 MR. GREIMAN: Yes.

24 MR. ROATE: Mr. Hayes?

1 MR. HAYES: Yes.

2 MR. ROATE: Ms. Olson?

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

4 MR. ROATE: Mr. Penn?

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

6 MR. ROATE: Mr. Sewell?

7 MR. PENN: No, Planning Area need.

8 MR. ROATE: Chairman Galassie?

9 CHAIRMAN GALASSIE: No.

10 MR. ROATE: Five votes in the affirmative,
11 four votes in the negative (sic).

12 CHAIRMAN GALASSIE: Motion does not pass.

13 (Pause)

14 CHAIRMAN GALASSIE: I'm going to recommend we
15 move on to 12-058 We have nine public comment requests,
16 seven supportive, two opposed. We will -- after public
17 comments, we will then break for lunch, and we will return
18 from lunch to address the presentation and vote on the
19 subject.

20 So, those members that have signed up for
21 public participation, Courtney will call off four or five
22 names, and if you would, please come up. You do not have
23 to be sworn in, but if you would introduce yourself and
24 spell your name and, again, recollecting the two-minute

1 limit for your public comment. Thank you.

2 MS. AVERY: We have Corine Holman,
3 Dr. Mohammad Shafi, Jerald Milligan, and Ronny Philip.

4 CHAIRMAN GALASSIE: Good morning, folks. If
5 you would just introduce yourself, spelling your name and
6 advise us if you're in support or opposing, and then give
7 us your comments. Thank you. And keep the microphone
8 close.

9 MR. PHILIP: Mr. Chairman and members of the
10 Board, I'm Ronny Philip, Regional Operations Director,
11 DaVita, and here to urge the Board to deny approval for the
12 US Renal. This application was deferred by Board Staff
13 prior to the last Board meeting, due to the applicant's
14 failure to appropriately document the need for a dialysis
15 facility in Lemont. For one, Staff has noted that it
16 appears that the pre-ESRD patients were used in support for
17 the US Renal Lemont and Plainfield applications, which, as
18 you know, is prohibited under the Board's rules.

19 The second basis for the deferral was that the
20 CON application data showed that only 9 patients residing
21 in the Planning Area HSA VII would be refused to the Lemont
22 facility, residing in HSA VII, and this is inconsistent
23 with your rules.

24 Since being deferred, nothing has changed. US

1 Renal did not provide additional information to address
2 Board Staff's concerns, such as additional referral
3 letters. Based on the data submitted and our knowledge of
4 this practice's patient base, which is almost exclusively
5 residing in HSA VIII in Will County, this application is
6 not supported by a patient base living within the Planning
7 Area, as required by this Board's rules. A facility in
8 Lemont is simply not justified, particularly when there are
9 two new facilities -- Palos Park Dialysis and US Renal in
10 Bolingbrook -- located less than 10 minutes away. A
11 facility in Crest Hill, which is adjacent to Joliet, would
12 have made more sense.

13 For this project, Northeast Nephrology
14 consultants project it will refer 23 patients --

15 MR. MORADO: Thirty seconds.

16 MR. PHILIP: -- from Joliet and 8 patients
17 from Crest Hill, to Lemont, even though the Lemont site is
18 over 20 minutes farther away from the patient base than the
19 Crest Hill site, which we had selected. Historically,
20 patients from these zip codes have been primarily referred
21 to the Silver Cross facilities.

22 In closing, I would sincerely once again urge
23 members of the Board to deny the US Renal Lemont project.

24 CHAIRMAN GALASSIE: Thank you, Mr. Philip.

1 Next, please.

2 MR. SHAFI: My name is Mohammad Shafi. I'm a
3 Board-certified nephrologist, practicing in the Joliet
4 area, and I'm here to oppose the US Renal application for
5 Lemont. I will try to be very brief but direct, and I
6 would echo the same sentiment as expressed by my previous
7 counterpart.

8 There has been a clear duplication of patients
9 for US Renal Plainfield's application and this for Lemont
10 also, which was removed from the last meeting agenda, due
11 to the Board's concerns. As yet, these concerns have not
12 been addressed by US Renal.

13 My second reason is, the project does not
14 serve the Planning Area it is located in according to the
15 Board requirements. Only 9 of the 80 patients live in HSA
16 VII. Therefore, it does not meet the service to the
17 Planning Area residents requirements. The application
18 states that the majority of the patients reside in a
19 five-mile radius of the proposed facility. The majority
20 live over five miles away and in a different HSA. The
21 identified patient base does not account for patient losses
22 between now and when the facility is operational. It does
23 not, therefore, have enough patients to support an 80
24 percent utilization.

1 Even if the patients were not duplicated --
2 add this to the fact that their new Bolingbrook facility --

3 MR. MORADO: Thirty seconds.

4 MR. SHAFI: -- and their proposed Plainfield
5 facility are all within 30-minutes travel zone, and
6 maldistribution and unnecessary duplication of services
7 will occur.

8 I thank you for the opportunity to come before
9 you today. Thank you for your time.

10 CHAIRMAN GALASSIE: Thank you, Dr. Shafi.

11 Good afternoon, ma'am.

12 MS. HOLMAN: Good afternoon. My name is
13 Corine Holman. I'm here to support the renal facility, US
14 Renal. I've been here before. This is my fourth time.

15 Everyone is saying how far something is away.
16 That doesn't matter how far it is. I think we, as the
17 patient, should have a choice as to where we want to go.
18 We might not want to go to Fresenius Medical. We might not
19 want to go to DaVita. Why can't we have a choice? It
20 is -- if you had someone on dialysis, how would you feel if
21 your family member didn't have a choice of where they
22 wanted to go? You're trying to make them go somewhere they
23 don't want to go.

24 I've been on dialysis for six years, and I

1 think that US Renal coming in to give people choices is
2 good. It's very good, because right now, I'm not where I
3 want to be. But do I have a choice? No. So are a lot of
4 patients where I am now. They can't make it here, but
5 thank God that I can come and speak on their behalf. And I
6 wish all of you all would just think about what I've come
7 to say for a time. I'm sure you can't forget who I am, and
8 I'm going to keep coming and keep coming and keep coming
9 until somebody change their mind to see how we feel.

10 Thank you very much.

11 CHAIRMAN GALASSIE: Thank you, Ms. Holman.

12 MR. MILLIGAN: Good morning. My name is
13 Gerald Milligan. I will try to keep this brief.

14 I am a dialysis patient, and I'm here fighting
15 for a choice of where I have to go for dialysis. Going
16 through dialysis is mentally, physically, and emotionally
17 exhausting. It's not like some operation, where you're in
18 a hospital for a couple of days, then you're done, and you
19 go home. If you think these Board meetings are long,
20 imagine having them three times a week, every week, for
21 basically the rest of your life. I mean no disrespect, but
22 have any of you ever been on dialysis or had a loved one
23 that's been on dialysis? It changes your entire life.
24 It's the kind of thing that you can really only know about

1 if you or a loved one has been there.

2 Being on dialysis is hard enough by itself.
3 I've been to a lot of clinics in the area, and they just
4 don't cut it. US Renal is my choice. It's 45 minutes away
5 from my home, but there's nothing close to me that is even
6 close to the care that I get at US Renal. So, 45 minutes
7 each way is two hours out of my day, plus on top of four
8 hours on dialysis. That's a quarter of my day is gone.

9 I have a nine-year-old daughter. She was
10 diagnosed with AD/HD. She goes to therapy once a week. I
11 would like to be there to go to her therapy. Sometimes I
12 can't, because I'm on dialysis, because I have to travel so
13 far. Lemont would be so much closer for me and so much
14 more convenient, and I could spend more time with my
15 daughter and less time sitting in a chair in some office 45
16 minutes away.

17 US Renal Care is the best renal outfit I have
18 been with. I have no complaints whatsoever. They've
19 treated me great. They're better than anybody else, and
20 they really go out of their way with the Mayo Clinic
21 philosophy: The patient's needs come first. And if anyone
22 wants to come see the place, you're more than welcome to,
23 because I can testify.

24 MR. MORADO: Thirty seconds.

1 MR. MILLIGAN: And please approve this
2 facility. My wife needs it. My daughter needs it. I need
3 it.

4 Thank you very much for your time.

5 CHAIRMAN GALASSIE: Thank you, Mr. Milligan.
6 Good luck to you.

7 We have, I believe, five more individuals
8 desiring to testify.

9 MS. AVERY: Barbara Revor, Dr. Chawla, Shirley
10 Tanguay, and Craig Corkery.

11 CHAIRMAN GALASSIE: Thank you. Welcome,
12 folks. Again, you did not have to be sworn in, but if you
13 would, introduce yourself and spell your name for the
14 record. And we will be starting with Dr. Chawla.

15 MR. CHAWLA: Good afternoon. I will make it
16 extra brief. I will not repeat the comments that have
17 already been made before me. I would like to point out
18 that Sun Health does offer an additional choice. It's
19 there for the taking. The only other thing I would say is,
20 this application misuses the reported need in HSA VII to
21 seek approval for a facility designed to serve patients in
22 HSA IX, which already has a surplus of stations. The
23 effect of this would be a back-door attempt to cause extra
24 duplication in HSA IX and the delusion of improvement in

1 service in HSA VII. Just keep that in mind, and I'll stop
2 here.

3 Thank you.

4 CHAIRMAN GALASSIE: And for the record,
5 you're opposed to the project?

6 DR. CHAWLA: Yes.

7 CHAIRMAN GALASSIE: Thank you.

8 MR. CORKERY: Good morning, ladies and
9 gentlemen. My name is Craig Corkery (spells name).
10 My wife and I reside in Lockport, Illinois. I

11 spoke in support of this project a few months ago at a
12 public hearing in Lemont. I wanted to come here again
13 today because of the possibility of a new facility in
14 Lemont. It's, again, very important to me.

15 When I learned there was a possibility that
16 there might be a new dialysis clinic in Lemont, I can't
17 even tell you how happy I was. I go to the public hearing,
18 which is right next to where the new Lemont facility would
19 be, and I made very good time from Lockport. This proposed
20 new location in Lemont would be very close to my home
21 versus going to my current renal center located in New
22 Lenox, Illinois. But more than anything, I would really
23 appreciate to have a choice for a new dialysis center place
24 to go.

1 I was a CEO and corporate service manager for
2 a third-party General Electric medical business for over 15
3 years and provided the Chicago area and outlying states
4 with nuclear medicine sales and services. I know what that
5 business should look like. My personal and business
6 observation of my current renal center operations in New
7 Lenox has become very questionable and becoming
8 unacceptable for myself, and also reflect the views and
9 opinions of patients that I have talked with. I, myself,
10 and other dialysis patients I talked with need a new
11 choice.

12 In conclusion, it would also be a blessing to
13 have (unintelligible) renal doctors. They are a great
14 group of dedicated, experienced and competent doctors, and
15 this new proposed renal facility in Lemont is a place I
16 would like to be in my care.

17 I thank you for your time today.

18 CHAIRMAN GALASSIE: Thank you, sir.

19 MS. TANGUAY: Hi. My name is Shirley Tanguay
20 (spells name). I'm here representing my husband, Norm, who
21 would love to be here, but he's on dialysis.

22 So, when I heard that US Renal care would be
23 thinking about coming to Lemont, this would be such a
24 blessing for both of us. Norman just turned 80 years

1 young, and we're, of course, looking to his 90 years young.
2 He's been on dialysis for four years. Two we did at home
3 and two we have been going to dialysis centers. Most of
4 the days these treatments just knock you for a loop. I'm
5 sure he could drive to the facility by himself, but there
6 is no way that he could drive home, because it knocks you
7 out so much. If anybody knows anybody who has gone through
8 this, you know that they come out of there really
9 exhausted. I would drive him myself, but, unfortunately, I
10 have never driven, and Norm is just too tired to do the
11 driving.

12 There's no public transportation in Lemont for
13 us to get anywhere. We've had to rely on volunteers from
14 our church. One woman even comes from Plainfield, which is
15 about 40 minutes, to pick him up, take him another 30
16 minutes to Orland, where the facility is, and then go back
17 home and then come back and do it all together, pick him up
18 and bring him home. All of these women have been a
19 blessing.

20 MR. MORADO: Thirty seconds.

21 MS. TANGUAY: It's very nerve wracking not to
22 know if your husband is going to make it to a medical
23 treatment -- which he needs to survive -- every week, three
24 times a week. I just want my husband to be comfortable and

1 not have to worry about this. This new dialysis center
2 that could be coming to Lemont is about four minutes from
3 our home. It would make such a difference.

4 If you approve this facility -- and I'm
5 praying that you do -- you are helping us to get our
6 independence and our focus back, and that's why I ask you
7 to please give us this blessing and approve the facility in
8 Lemont. You have no idea how much it would mean to us.
9 Thank you.

10 CHAIRMAN GALASSIE: Thank you, Ms. Tanguay.

11 Good afternoon.

12 MS. REVOR: Good morning. Barbara Revor
13 (spells name).

14 I wish there were some magic words that I
15 could use to explain to all of you this morning that would
16 help you understand how very important this facility is to
17 at least Mr. Tanguay and Lemont. I'm one of four permanent
18 drivers who drive him back and forth. We're just a
19 collection of people. We do it because we love Mr. Norm,
20 because he's very important in our lives. One is a mom who
21 brings her toddler. One is a working woman who picks him
22 up and brings him home. We have the lady from Plainfield
23 who comes and takes him. She brings her grandson, who is
24 less than a year old, with her. And then I drive on

1 Fridays.

2 Thirty minutes is not thirty minutes. It's
3 thirty minutes bus traffic or weather or whether or not
4 your patient makes his time out on time. So it's a great
5 deal of volunteering. I estimate we probably put in eight
6 to ten hours each week, waiting for our patient and driving
7 him to and from our house, his house and the facility. If
8 the place in Lemont is opened, I estimate it will run down
9 to about an hour a week for timing.

10 And, also, as I drive back and forth Mr. Norm,
11 his main concern is his wife, who does not drive, and he
12 would very much appreciate this facility being opened.

13 Thank you.

14 CHAIRMAN GALASSIE: Thank you.

15 Does that conclude public comments? No? Two
16 more.

17 MS. AVERY: Teresa Kravets and Aaron
18 Gurfinchel.

19 CHAIRMAN GALASSIE: Good afternoon.

20 MS. KRAVETS: Hi. I'm Dr. Kravets, Teresa
21 Kravets (spells name). I'm (unintelligible) Northeast
22 Nephrology Consultants. I've been in practice for 17
23 years. I came to Joliet (unintelligible) Illinois, and I
24 enjoy practicing in this community.

1 I was really happy to hear that US Renal
2 wanted to open a dialysis center in Lemont, and I know
3 there is a need there for this center, dialysis center. In
4 our group we have five nephrologists, (unintelligible) 75.
5 We've been -- our practice has been here for about 30
6 years, and we are the largest practice in the area. I know
7 you have Dr. Chawla and Dr. Shafi opposing. Dr. Shafi has
8 been here for about four years. He came from southern
9 Illinois. Dr. Chawla has been here longer than me, and I
10 enjoy working with him, but he has a financial reason to
11 oppose our project, which is unfortunate.

12 I think it's beneficial for our patients. I
13 think it's beneficial for us as a physician to have a
14 choice --

15 MR. MORADO: Thirty seconds.

16 MS. KRAVETS: -- to send our patients to the
17 best place that they can get care. We have about 3,900
18 chronic kidney disease patients in our practice. We have
19 about 230 dialysis patients right now, over a hundred
20 prospective patients that we care for.

21 Our Medicaid rate is about 7 percent, which is
22 the national rate. I know that compares to the national
23 rate. We have never turned the patients for their ability
24 to pay. And we have about 70 patients from the Lemont

1 area, about another 70 from Orland Park, Homer Glen; not
2 Lockport, which is very close to some of the units.

3 So, I strongly feel that there is enough
4 practice in this area that can support Lemont unit that's
5 needed. Our practice, I think, has the best results to
6 support it, and, once again, I'd like to thank you for
7 hearing our project today.

8 CHAIRMAN GALASSIE: Thank you, Doctor.

9 Good afternoon.

10 MR. GURFINCHEL: Good afternoon. My name is
11 Aaron Gurfinchel (spells name). I am a nephrologist with
12 Northeast Nephrology Consultants, and I am talking here now
13 in support of the Lemont dialysis unit.

14 When I see how some other physicians are
15 opposing our unit, in what seems to me an obsessive way, I
16 ask myself, what are the true reasons for this? Are they
17 doing this because of what they say, that they are patient
18 advocates, or are they doing this for the patient benefit,
19 or duplication of units or chairs, et cetera? Or is it
20 because they have an interest? Are they looking at us like
21 we are a threat to them because we want to open another
22 unit and they are afraid to lose patients in their own
23 units? Is that the real motive that they have to oppose in
24 such a vehement way that I -- believe me, I think

1 quorum. A couple members are on their way but will be
2 straggling in shortly.

3 We are out of recess, and we are coming back
4 to Item -- Application 12-058, US Renal Care Lemont. We
5 have completed the public comment portion. I would call
6 the representatives from US Renal to the table, and if you
7 would introduce yourselves, utilizing the microphone, and
8 spelling your names, we will have you sworn in.

9 (Pause)

10 MR. VINSON: Thank you, Mr. Chairman. My
11 name is Sam Vinson (spells name).

12 MR. PIRRI: My name is Steve Pirri (spells
13 name).

14 MR. RAUF: My name is Anis Rauf (spells name),
15 physician with US Renal Care.

16 MS. NAGARKATTE: Good afternoon. My name is
17 Preeti Nagarkatte (spells name).

18 CHAIRMAN GALASSIE: Thank you very much.

19 (Oath given)

20 CHAIRMAN GALASSIE: Mike, Staff report
21 please.

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

23 The applicants are proposing to establish a
24 12-station ESRD facility, located in approximately 6,500

1 gross square feet of leased space in Lemont. The proposed
2 cost of the project is \$2.4 million. There was no -- the
3 anticipated completion project date is April 1st, 2013.

4 Thank you, Mr. Chairman.

5 CHAIRMAN GALASSIE: Thank you.

6 Would someone like to address the Board?

7 MR. VINSON: Mr. Chairman, as I said, my name
8 is Sam Vinson. I'm with Ungaretti & Harris. We represent
9 US Renal, and I'd like to introduce to you the CEO of US
10 Renal, Mr. Steve Pirri, to discuss the company and his
11 philosophy.

12 CHAIRMAN GALASSIE: Thank you.

13 MR. PIRRI: Good afternoon. As Sam said, my
14 name is Steve Pirri. I've been with US Renal the past
15 seven years.

16 We're here today because last month, in a
17 Planning Board meeting, the Board voted an Intent to Deny
18 the proposed US Renal Care project. We want to make sure
19 we've addressed all of your concerns on this particular
20 project in HSA VII, because there are now 50-plus stations
21 that are under utilized and we would like your approval on
22 that project. Beyond there being an established need for
23 more stations, let me clarify why US Renal Care is the
24 right organization to meet the needs of the patient in this

1 area.

2 First, from approval to treating the first
3 patient, US Renal Care has proven that we can open our
4 dialysis clinics and serve our first patient in less than
5 one year's time, which is unique. History in Illinois has
6 shown it takes far longer -- sometimes double the time --
7 for providers to open their facilities once approved.

8 Our philosophy is, we use a joint venture
9 model. We want to do what's best for the patient. The
10 joint venture model is with all our dialysis centers. What
11 it does is partner with physicians, where they have an
12 equal stake with us in our clinics. This is an important
13 reality about our organization I want to clarify, and it
14 has a direct correlation to patients, payors, regulators,
15 employees, and joint venture physicians. US Renal Care
16 opted for the joint venture model, because the medical
17 model has empirical evidence suggesting that joint venture
18 models have a direct correlation to quality of care and
19 patient satisfaction.

20 After we were approved for our first three
21 dialysis centers back in the fall of 2011, the industry's
22 largest provider, Fresenius Medical, was quoted in Crains
23 on October 25th, 2011, saying they were going to sell
24 stakes in 21 dialysis centers in the Chicagoland area; the

1 reason -- and I quote -- "The minority owners will help the
2 company run its clinics more efficiently while ensuring a
3 high quality of care. They bring insight from a quality
4 and clinical standpoint, and also from an operational
5 standpoint." I guess if the largest provider in the
6 industry endorses our model, it must be good for a reason:
7 Because it works and it drives values for patients. We've
8 known that for a long time, and we are pleased patients
9 have noticed a difference in care under this model. So, it
10 has caught the attention of other providers.

11 While partnering with the leading physicians,
12 the patients will benefit. If you did not know this, in
13 the future dialysis companies will be penalized, through
14 reduced reimbursement rates, for not meeting quality
15 standards and guidelines. As such, we are confident that
16 our strategic alliance is in the best interests of all
17 stakeholders, including patients, physicians, and
18 communities we serve.

19 Previously, many of you have heard physicians
20 discuss the significant advantages that US Renal Care model
21 offers to the patients. Essentially, we establish joint
22 venture partnerships with select physicians in our dialysis
23 centers. It is of paramount importance, especially when
24 dealing with gravely-ill patients, to choose the right

1 physician partner. As such, we are -- as such, the
2 physician credentialing due diligence process is very
3 extensive. We have a whole host of people involved, which
4 has led us to our Chief Medical Officer, Stan Lindenfeld.
5 It is a typical step for us to set up medical advisory
6 boards in the states we serve.

7 With the USRC Dialysis in Oak Brook,
8 Bolingbrook and Streamwood, we're serving patients. We're
9 prepared to take this next step.

10 I would like to introduce one of USRC's
11 physician partners, who will speak about the USRC Medical
12 Advisory Board model. This physician's name is Dr. Anis
13 Rauf, who is deeply involved with our dialysis center and
14 has been in dialysis for a number of years and is here to
15 talk about that model.

16 DR. RAUF: Good afternoon. My name is
17 Dr. Anis Rauf. I trained at the Mayo Clinic in Rochester,
18 Minnesota, as well as Loyola.

19 When I first started practice five years ago,
20 I only knew one thing: The needs of the patient come
21 first. As one of my patients spoke earlier, one of the big
22 models of the Mayo Clinic was, the best interests of the
23 patient is the only interest to be considered, and that's
24 something that my partners and I truly believe in.

1 US Renal Care attracted me first, because, as
2 I was looking out to partner with the right company, I had
3 multiple offers from large corporations, wanting to work
4 with me, since I had a growing practice in the area. It
5 was extremely difficult for me to grow and build my
6 practice, because it was very difficult to not only get
7 privileges, but also get coverage.

8 As a physician, I believe it's very important
9 to have input in the operations of the dialysis facility,
10 because your one individual patient may need one-on-one
11 time with their physician. They may need a bigger
12 dialyzer. They may need an extra pillow. They may need
13 something to offer them for their back pain. They spend
14 four hours, three times a week in dialysis. They may need
15 help with transportation. I believe that is my
16 responsibility for each and every patient that I take care
17 of. I owe it to them to do whatever I can, and if it means
18 that I make less money and I take home less, that's okay,
19 because that's what I signed up, the Hippocratic Oath,
20 where I believe the best interests of the patient is the
21 only interest to be considered.

22 US Renal Care has allowed me to develop the
23 type of dialysis unit I've always wanted to develop for my
24 patients. I always thought about if I were on dialysis --

1 God forbid -- or if my family member were on dialysis, what
2 type of environment would I want them to be? I would want
3 them to be in an environment that's comfortable, that's
4 quiet, that is providing topnotch quality; and as I invited
5 folks before, I invite them to come and see our model and
6 see how it's attracted attention. I've been fielding calls
7 from medical directors from other facilities all over the
8 state that would like US Renal Care to participate in
9 developing their areas, and this is why I'm here today to
10 share with you that I've been involved, from day one, in
11 the Medical Advisory Board with US Renal Care, and the goal
12 is to provide utmost quality for our patients and not just
13 worry about the pot of money.

14 I know the Lemont area well. Our patients
15 from our individual practice in the Oak Brook/Bolingbrook
16 area do come from Lemont, and I think there is a serious
17 need in Lemont, and I do think that providing utmost
18 quality and the choice to the area of the residents in
19 Lemont will (unintelligible). Currently, in our Oak Brook
20 facility, we've got patients coming from 45 miles away,
21 just because they want that quality that US Renal Care is
22 able to provide. And I kid you not, this is, by far, a
23 changing scene in the way dialysis should be done, and I
24 think that the Illinois market can set an example for the

1 rest of the country.

2 Thank you.

3 CHAIRMAN GALASSIE: Thank you, Doctor.

4 MR. VINSON: Mr. Chairman, I would like to
5 walk you through a couple of charts that demonstrate this
6 area and the need in this area. As you can see, this is
7 the Lemont area (indicating). This line right here is the
8 Cook County border and the Cook County border for this part
9 of it is the difference between Region VII and Region IX.

10 CHAIRMAN GALASSIE: The yellow and the blue?

11 MR. VINSON: Yes, sir. And if you look at
12 Lemont, it is right on the border. You might describe it
13 as the West Berlin of this area. The fact of the matter is
14 that patients are going to go between IX and VII with some
15 frequency. Patients are going to go based upon their
16 choice of doctors and based upon their choice of
17 facilities, and to think that simply because Lemont at this
18 point is close to the border and some patients will be
19 coming across the border is a mistake. It's a mistake not
20 only because of the fact that these patients are going to
21 do, to a substantial extent, what they want to do, but it's
22 a mistake also in the calculation of need, and I'd like to
23 take you to that, and I'd like to take you through the
24 process that we've done on that first, the actual projected

1 need calculation.

2 This is derived from your rule. It is not
3 precisely like your rule, and I don't want to misrepresent
4 it to you that it is. What your rule actually does is to
5 calculate the existing dialysis prevalence, based upon a
6 report from a federal agency. What this does is to take
7 the various populations and to take their prevalence and to
8 calculate it based on that, and then we've taken it a step
9 further out to 2013, and then I'm going to show you what
10 happened to 2014.

11 CHAIRMAN GALASSIE: So you're taking our
12 calculated methodology out to 2014?

13 MR. VINSON: What I'm saying is this: Your
14 calculation has not taken -- it's not relied upon the 2010
15 census data yet. I'm sure it will. I'm sure there are a
16 number of problems there that Mr. Carvalho has explained in
17 the past. You're going to get that number sooner or later,
18 and I want to show you essentially what that number is
19 going to do.

20 You currently have a need in this Planning
21 Area of 51 stations. When it's done, when your calculation
22 is done, you're going to end up with a need of about 82
23 stations, 31 more. The reason for that is the change in
24 the population mix of the Planning Area. The Planning Area

1 has gotten approximately 200,000 more Hispanics. The
2 Planning Area has gotten approximately 100,000 more African
3 Americans in the decade. The result of that is that the
4 need for dialysis is much greater. Dialysis is not
5 something that is evenly distributed among the population.
6 The rate among Hispanics is roughly 1.6 greater than the
7 general population. The rate among African Americans can
8 be as high as three times the general population, and, as a
9 consequence, when the population mix within a Planning Area
10 changes dramatically, as it has in this case, then the
11 result is that there is a much greater need than you would
12 typically think.

13 There's nothing tremendously wrong with your
14 fundamental formula, and I don't mean that there is. It's
15 just the fact that the population mix in a Planning Area
16 makes a huge difference, because of those differences in
17 disease prevalence, and if you take a look at these numbers
18 and you recognize that you're going to need these increased
19 numbers of stations when your get your data for the period
20 of 2012, 2013, and 2014, the result is that you run the
21 serious risk of fishing behind the net. It takes
22 approximately a year for US Renal to put a facility on
23 line. Some other people in the marketplace take quite a
24 bit longer than that year to put a facility in the

1 marketplace; and as a consequence, unless it's possible for
2 you to look at these things now and to address the need
3 now, these populations are going to be greatly behind.

4 I might finish by saying one last thing. The
5 Planning Board that Anis Rauf is on, the Medical Advisory
6 Panel, is in the process of creating a new initiative that
7 will deal with this need in an even greater way. As we
8 have placed in our application and reported to you, there
9 is substantial medical evidence -- a great deal of it
10 derived from the University of Illinois in Chicago, from
11 its medical school, but it's true nationally as well --
12 that, in fact, there is quite a bit of under-diagnosis of
13 Hispanics, particularly on the question of kidney disease,
14 and the under-diagnosis of Hispanics with kidney disease
15 leads to a failure to refer and a failure to get to a
16 nephrologist and a failure to get ultimately to dialysis.
17 You've all heard stories, I'm certain, of the situation
18 where somebody walks in and they're already at Stage 5 and
19 should be on dialysis. Numerous doctors talk about that
20 and that's because of an under-diagnosis. And so what the
21 Medical Advisory Panel of USRC is going to do is work with
22 a select group of foundations in Chicago, yet to be
23 identified, and a select group of medical and science
24 professionals from the medical schools to try to analyze

1 how to cut through this under-diagnosis problem. When
2 that's accomplished, one of the effects will be a dramatic
3 increase in need, even more.

4 And so, for those reasons, I submit to you
5 that there is substantial need in this Planning Area
6 currently, by your actual formula. There is more because
7 of the failure to rely on the 2010 numbers, and when you
8 have things like Obama Care kick into place, and eliminate
9 the insurance problem, and when you cut through, as
10 Dr. Rauf's planning board will attempt to do -- when you
11 cut through the cultural problem of referral, you could see
12 substantially greater need; and for those reasons, I would
13 submit this is a project that should be approved.

14 CHAIRMAN GALASSIE: Thank you very much.

15 I will open it up to the Board for questions.

16 Member Sewell?

17 MR. SEWELL: Yes. Thank you for that
18 explanation. I'm kind of intrigued with your first one,
19 though, where the proposed site is so close to HSA IX,
20 because in the State Agency Report, it looks like there's
21 under utilization of existing facilities in HSA VII. Do
22 you know what the utilization looks like in HSA IX?

23 MR. VINSON: You actually have too few
24 facilities in HSA VII. Your report suggests there are too

1 many in HSA IX. I've not created this data to the extent
2 of actually predicting the number if you had different
3 population figures with population mix. I am certain -- I
4 do know and have looked at the fact that both the Hispanic
5 population and the African American population has
6 substantially increased in HSA IX, and I suspect that
7 you're going to have the situation where the projected
8 number of facilities required is increased, and you will
9 see that the need issue drops away.

10 CHAIRMAN GALASSIE: I wonder if
11 Mr. Constantino could answer Mr. Sewell's questions.

12 MR. CONSTANTINO: There are facilities in HSA
13 IX that are under utilized, Mr. Sewell, based on the
14 information we have, based on our formulas and the data,
15 the 2000 data we have.

16 CHAIRMAN GALASSIE: Member Olson, Judge
17 Greiman, and then Member Penn.

18 MS. OLSON: I like your model, but I have a
19 few questions. Are your Oak Brook and Bolingbrook
20 facilities open yet?

21 MR. PIRRI: Yes, they are. They are starting
22 to serve patients. We're waiting on the final Medicare
23 certification.

24 MS. OLSON: And do you have any indication how

1 soon those two facilities will be --

2 MR. PIRRI: -- accepting Medicare patients?

3 MS. OLSON: -- at target? What is your
4 prediction to be at State target occupancy?

5 MR. PIRRI: We look at it probably over a
6 three-year period where we will get to that eighty percent.

7 MS. OLSON: And still, you want to open
8 another facility in that area, even though we are probably
9 two years or three years out?

10 MR. PIRRI: It's with a different patient
11 base. We're with a different physician group that is
12 partnering with us in that HSA VII, as the physician here
13 will tell you and the other two physicians will tell you.
14 It's a five-man --

15 MS. OLSON: But these other two facilities are
16 within -- I drove from Wheaton here this morning. I kind
17 of went -- but it didn't take me very long to get -- I
18 actually dropped my grandchildren off in Oak Brook and
19 drove to here, and I went through the city traffic. I
20 didn't even get on the big, main roads, and it only took me
21 maybe 25 minutes. But yet you still feel the need for a
22 third in the same Planning Area?

23 MR. PIRRI: Yes, we do.

24 CHAIRMAN GALASSIE: Judge Greiman?

1 MR. GREIMAN: Yes. I just want to ask a
2 couple quick questions about how doctors become partners
3 with you. So, do they buy in or what -- how do doctors --
4 what percentage do you sell to doctors?

5 MR. PIRRI: Typically it's 60/40, where US
6 Renal Care is a 60 percent owner and the physicians are a
7 40 percent owner.

8 MR. GREIMAN: And so when a doctor comes in,
9 does he have to put down some money.

10 MR. PIRRI: They have to fund it equally to
11 their percentage share.

12 MR. GREIMAN: So, in this case, roughly what
13 are we talking about, a million? So the doctors would have
14 to come up with \$400,000.

15 MR. PIRRI: They would come up with a portion
16 of that. We would finance the rest. Both sides would
17 finance --

18 MR. GREIMAN: I understand. I use -- the cash
19 figure in this deal is a million dollars, so they have to
20 come with \$400,000. And have they done that? Are they
21 partners already?

22 MR. PIRRI: Yes.

23 MR. GREIMAN: They've paid their \$400,000.

24 MR. PIRRI: They'll pay the 400,000 once we're

1 approved. They've paid their expenses along the way, but
2 once we have approval -- we already have the final
3 documents, they've already put down a deposit, and then
4 once it's approved, then the rest has to get funded.

5 MR. GREIMAN: All right.

6 CHAIRMAN GALASSIE: Member Penn?

7 MR. PENN: I have a question for Mike first.

8 You listened to the presentation. Do you
9 agree with those numbers, those projections, using the 2010
10 census?

11 MR. CONSTANTINO: We do not have 2010 census
12 data, David. We're still using 2000 census data. We
13 should --

14 MR. BURDEN: We can't hear you down here,
15 Mr. Constantino.

16 MR. CONSTANTINO: We don't have 2010 census
17 data yet. We should have it the first of next year, first
18 quarter of next year. We're doing our projections. I
19 haven't looked at any of the 2010 data.

20 MR. PENN: I was just getting your opinion, if
21 you thought the presentation was more accurate than it was
22 less accurate.

23 MR. CONSTANTINO: I couldn't render an opinion
24 on that.

1 MR. PENN: That's fair. It wasn't a fair
2 question.

3 I guess the other question is, do you have a
4 completion --

5 CHAIRMAN GALASSIE: They didn't hear.

6 Member Penn wanted to know if Mr. Constantino
7 could render an opinion whether it was more accurate or
8 less accurate, and Mike has preferred not to render an
9 opinion at all.

10 MR. PENN: And I apologized for that question
11 to Mike.

12 Completion date: April 1st, 2013, if this
13 application is approved. Is that -- 2013, April 1st, three
14 months to get this project completed? Is that accurate?
15 90 days?

16 MR. VINSON: Well, that's precisely what we --
17 we only filed that at the time because we thought that
18 would be correct, I suspect, without knowing -- and, Steve,
19 you may want to say something about this. But I suspect
20 that given the fact that we deferred, if we were approved
21 now, it might be a month or so later.

22 MR. PENN: Still within four or five months.
23 That's a lot shorter time frame than most applicants have
24 asked for, and being fair to you and the comments I heard

1 earlier -- 16 months, 18 months, so on and so forth -- I
2 don't want to put you behind a rock just getting started.
3 But you think you can complete this in four to five months,
4 three, four, five months?

5 Can we make an adjustment?

6 MR. CONSTANTINO: They'll have to come in for
7 a permit renewal if you approve this project.

8 MR. PIRRI: It depends on the location, and
9 when I say that, if it's free-standing construction, from
10 ground up, it's going to take longer. If it's already an
11 established building and the inside is going to be gutted
12 and retrofitted to a dialysis center, the time frame is
13 much shorter.

14 MR. PENN: I'm just trying to be fair.

15 MR. PIRRI: I appreciate that.

16 CHAIRMAN GALASSIE: Mr. Carvalho?

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

18 Three points and questions I'd like to make.
19 First, as with most facility types, your need analysis is
20 not unidimensional. So, for example, there is an inventory
21 that hospitals, ESRD's, others create that shows, quote,
22 need, end quote, in an area is. But that's usually one
23 measure, and that's why with respect to most of those
24 facilities, the other measures you look at are the

1 utilization, and you'll see many times where one criteria
2 is met but the others are not. So, for example, it may
3 show that there is a need for stations, but then when you
4 look around, you find that many stations are under
5 utilized; or there's a need for beds, but when you look
6 around, many of the beds are under utilized. So, your
7 bottom line decision on need is not driven by one data
8 point, but looking at all of those criteria, especially, as
9 Mr. Vinson points out, where you've got some concern about
10 population numbers and other things that feed into that
11 need criteria. So, first point is a reminder that your
12 criteria are not one-dimensional.

13 The second: It makes me very nervous to try
14 to do revised need calculations on alternative
15 methodologies on the fly at a meeting. Even though I may
16 be an applied math major, it's still an awful lot to try to
17 keep in your head, live at a meeting. But, Mr. Vinson, I
18 think there is something misleading about what you're
19 saying about the population numbers, and let me explain
20 why. Our need calculation looks to the population numbers
21 to know the number of people who are in an area. Our
22 calculation doesn't look at demographics of the people who
23 are in an area. It looks at the numbers. The way the
24 demographics of a population would affect our need

1 calculation is, we look at the utilization, the historical
2 utilization, and if the population in an area is changing,
3 that will impact the utilization in that area and that will
4 feed into the calculation going forward. So, whether or
5 not we are using current, new, projected, any type of
6 census data will not impact our need calculations with
7 respect to the demographics of the population, because
8 that's not the source of the information for the
9 demographics. The source of information on the
10 demographics is the utilization. As the utilization
11 changes because demographic changes, it will impact the
12 formula. Those utilization numbers -- I do not know. Mike
13 may. You refresh the utilization numbers frequently, don't
14 we?

15 MR. CONSTANTINO: We do the monthly update on
16 the need calculation in our monthly updates. However, the
17 utilization is a historical utilization and then averaged
18 over three years.

19 MR. CARVALHO: So that gets refreshed -- it's
20 historical, because we don't know the utilization last
21 week, but it gets refreshed on a regular basis, regardless
22 of what census data we're using.

23 MR. CONSTANTINO: That's correct.

24 MR. CARVALHO: In preparation for these

1 meetings, you always go back and look at the minutes to see
2 what words need to be changed, and I notice that the point
3 I'm about to make I precisely made at the last meeting.
4 So, I will just refresh your recollection.

5 There was testimony earlier about patient
6 choice, and it's very compelling testimony when you --
7 especially when you hear it from the patients. However,
8 there is an inconsistency between providing surplus
9 facilities in order to facilitate patient choice and a
10 decision whether or not to have a Certificate of Need
11 process for this category of service. The Legislature
12 considered that during the Task Force on Healthcare Reform.
13 A proposal was on the table from certain providers to
14 eliminate jurisdiction for end stage renal dialysis. The
15 Legislature chose to keep that jurisdiction.

16 You either have to decide that you're going to
17 allow surplus facilities to be built in order to facilitate
18 patient choice -- in which case it's not clear why you have
19 the Certificate of Need process -- or you have the
20 Certificate of Need process. But in some respects, that's
21 really a decision for the Legislature, not sort of an ad
22 hoc thing as applications come in.

23 The part where I have a question for you is
24 the model. It seemed ironic to me that some of the

1 testimony by members of the public was calling into
2 question the opponents of this application, by stating that
3 they have a financial stake. But your model is designed
4 around giving your doctors a financial stake -- if I
5 understand it right, they're 40 percent owners -- and then
6 also on the predicate that the financial stake is the
7 vehicle by which doctors have some say-so on the
8 operations. And the reason why that struck me as odd is,
9 90 percent of our hospitals don't have any financial stake
10 by the doctors, but the doctors drive issues of quality and
11 care in the institution. So, the vehicle of ownership is
12 not the only mechanism by which doctors can drive issues of
13 quality. It would seem that ownership also can drive
14 participation, which is to say, since all of these
15 facilities depend on doctors to refer patients to them --
16 nobody just knocks on your door and says, "I need dialysis"
17 -- couldn't -- what assurances or what can you tell us to
18 make it clear that the ownership stake that you're offering
19 isn't more driven by capturing the patients of the doctors
20 who are provided the stake, rather than the concern to use
21 this particular mechanism to ensure quality?

22 MR. VINSON: I'm certainly going to let Steve
23 Pirri address that. I want to call a couple things to your
24 attention first.

1 The first thing is the nature of kidney
2 disease, which is a little bit different from some disease
3 situations that people face with institutions. As I
4 understand it, you get to the level of CKD 5, where you
5 need dialysis, when you have less than 15 milliliters per
6 minute flow through the kidneys. That is a strikingly
7 empirical number. I believe that is somewhat different
8 than the situation I faced, for example, when the
9 physicians looked at me and said they did not know whether
10 I had an abscess of the brain or a tumor in the brain, and
11 they had to go in there and try and figure out which it
12 was. You might use that to explain some things about my
13 presentation, I suppose, Dave. But all of that said, you
14 have a pretty hard-line number with dialysis. That
15 hard-line number is predictive enough that when Congress
16 decided to look at Stark and to impose Stark, it imposed
17 Stark on a particular set of conditions. It imposed Stark
18 particularly on those conditions where there was concern
19 that physicians might make subjective judgments and the
20 judgment might be -- might end up in a self-interest
21 situation.

22 In this situation, Congress chose not to deal
23 with dialysis in that framework; and it chose not to,
24 because it found that the need for dialysis, the predictive

1 need for dialysis, was such a hard-line number that it did
2 not need to worry about that. That's what I can say to you
3 as a lawyer analyzing this.

4 I'm going to turn this over to Steve to let
5 him talk to you about how he chooses doctors and how his
6 staff chooses doctors, because the real thing you get down
7 to in this is, you've got to choose the right doctors.
8 That's what they focus on the hardest. I've listened to a
9 lot of lectures on this, and so I'm going to let him talk
10 about it.

11 MR. CARVALHO: Before you do, let's deal with
12 the legal issue. What Stark was about -- what Congress was
13 concerned about in Stark was that extra services would be
14 offered beyond what were medically necessary, if physicians
15 had financial interest, and so they might be inclined, when
16 they had a financial stake in a healthcare facility, to
17 over-provide services.

18 MR. VINSON: Yes, that's precisely right.

19 MR. CARVALHO: But Congress knew in the case
20 of dialysis that if you meet those measures that you
21 indicated, that they were going to be paying for the
22 patient some place, and so the Congressional interest as
23 the payor -- whether it was in Facility A or Facility B --
24 was a no-never-mind the Congress. So, as you say, it

1 wasn't included.

2 This Board has a different issue. This Board
3 has an issue of how many facilities are needed. So there,
4 the question about if somebody is going to get moved or
5 have a reason to send patients to a new facility and come
6 in and say, "We need this new facility, because I have
7 these patients who need to be cared for." But the way
8 those patients are going to be in that new facility is
9 because they are going to be drained from some other
10 facility that they were originally using. From the
11 Congressional perspective, that's not needed to be
12 regulated, but from the State's perspective on need, it's a
13 different consideration. So Congress's determination was
14 not to include the Stark protections in this case.

15 MR. VINSON: You're absolutely right, that the
16 concern with Stark was a little bit different than the
17 concern here.

18 CHAIRMAN GALASSIE: Mr. Vinson, I'm going to
19 interrupt you, and I do it respectfully, but, gentlemen,
20 I'm sure I'm the only member -- the rest of the Board
21 members are astutely aware of what both of you are talking
22 about. But I'm losing relevance, to be quite honest with
23 you. The issue at the table is the manner in which Renal
24 Care employs docs. I think the Board is fully aware, based

1 upon the amount of these applications we deal with, how
2 physicians are recruited, why they're recruited, and there
3 is an ownership relationship that Member Penn discussed
4 that exists. I think we get that. I don't think we need
5 further definition of the relationship.

6 That having been said, other questions from
7 Board members on this?

8 MR. CONSTANTINO: Mr. Galassie?

9 CHAIRMAN GALASSIE: Mr. Constantino.

10 MR. CONSTANTINO: I would like to point out to
11 the Board, we had some concern about this project and the
12 Plainfield project 12-059. It appeared to us that there
13 might be a duplication of referral information, duplication
14 of patients, and I would ask the Board -- this application
15 needed to be heard at this meeting, and I would ask the
16 Board to defer this project until such time as we get an
17 explanation -- a Board deferral.

18 CHAIRMAN GALASSIE: Okay. We are all
19 interested in your comment, Mike. Your comment begs the
20 question: Why are we asking for that now as opposed to
21 when we did our Staff report?

22 MR. CONSTANTINO: Well, I had discussed
23 this -- when you initially extended the review period on
24 it, we had concerns about this information, and we got no

1 response. There was no response to that -- to our
2 expression of concern to the applicants.

3 CHAIRMAN GALASSIE: So, again, perhaps it's
4 the time of day. Bear with me. So, Staff is asking for a
5 deferral of this project, because we asked for information
6 that has not yet been responded to?

7 MR. CONSTANTINO: Right. We need a response
8 to the information whether or not there are duplicates in
9 these two applications, 12-058 --

10 CHAIRMAN GALASSIE: Right, as was noted in
11 our file. But, again, I would encourage you to verbalize
12 that in the beginning with Staff report.

13 The Board has heard Staff's recommendation in
14 regards to choosing to defer -- recommending to defer this
15 project. That having been said, I will make the motion to
16 approve. If that motion is moved and seconded, we will
17 vote. If not, I suspect we will have a second motion.

18 May I have a motion to approve Project 12-058,
19 US Renal Care Lemont Dialysis, authorizing the
20 establishment of a 13-station ESRD facility in Lemont,
21 Illinois?

22 MR. BURDEN: So moved.

23 CHAIRMAN GALASSIE: I hear a motion, but --

24 MR. HAYES: Second.

1 CHAIRMAN GALASSIE: There is a second.

2 Motion and second. Vote, please.

3 MR. ROATE: Motion made by Dr. Burden,

4 seconded by Mr. Sewell.

5 Mr. Bradley?

6 MR. SEWELL: No, Mr. Hayes.

7 MR. ROATE: Mr. Hayes. All right. Thank you.

8 Mr. Bradley?

9 MR. BRADLEY: I'll vote no.

10 MR. ROATE: Dr. Burden?

11 MR. BURDEN: I vote no.

12 MR. ROATE: Senator Demuzio?

13 MS. DEMUZIO: No.

14 MR. ROATE: Justice Greiman?

15 MR. GREIMAN: No.

16 MR. ROATE: Mr. Hayes?

17 MR. HAYES: I vote yes.

18 MR. ROATE: Ms. Olson?

19 MS. OLSON: I'm going to have to vote no.

20 MR. ROATE: Mr. Penn?

21 MR. PENN: No.

22 MR. ROATE: Mr. Sewell?

23 MR. SEWELL: No.

24 MR. ROATE: Chairman Galassie?

1 CHAIRMAN GALASSIE: No.

2 MR. ROATE: Eight votes in the negative, one
3 vote in the affirmative.

4 CHAIRMAN GALASSIE: Motion does not pass.

5 MR. URSO: You're going to be receiving an
6 Intent to Deny. You'll have an opportunity to submit
7 additional information and appear before the Board again.

8 CHAIRMAN GALASSIE: Good luck.

9 Moving on to Item 12-085, DaVita Lawndale
10 Dialysis. There is no public comment participation
11 requests.

12 Would representatives from DaVita come up and
13 introduce yourselves, please. Spell your names for our
14 recorder, and we'll have you sworn in.

15 (Pause)

16 MS. DAVIS: Penny Davis (spells name).

17 MS. FRIEDMAN: Kara Friedman (spells name).

18 MR. ANEZIOKORO: Ogonnaya Aneziokoro (spells
19 name).

20 MR. FRANKEL: David Frankel (spells name).

21 (Oath given)

22 MS. AVERY: I apologize. I overlooked two
23 public participation requests. So, we'll take those.

24 CHAIRMAN GALASSIE: Sorry. I didn't realize

1 it was for this one. If the -- we have Forrest Harris and
2 August Sallas.

3 (Pause)

4 CHAIRMAN GALASSIE: If you two gentlemen would
5 just introduce yourself, let us know if you are opposed or
6 supportive, and spell your names for the record. You do
7 not have to be sworn in.

8 MR. SALLAS: Okay. My name is August Sallas
9 (spells name). Thank you. And I'm the President of the
10 Little Village Community, Council of Little Village. I've
11 lived there 33 years. I was born in Chicago, and we are
12 opposed to the DaVita Lawndale Dialysis Center in the
13 Little Village Community.

14 Our community is predominantly Mexican. I'm
15 Mexican-American myself, and I read and learned about a CNN
16 investigation, a special investigation -- I won't read it;
17 I would ask the Board members to get a copy of it --
18 alleging that DaVita is involved in master fraud that
19 involves Medicare and Medicaid that it charges to our
20 federal government, which is taxpayers' money. So we stand
21 opposed to have DaVita Lawndale dialysis in our community
22 on that basis.

23 CHAIRMAN GALASSIE: Okay, Mr. Sallas. Thank
24 you.

1 MR. HARRIS: My name is Forrest Harris (spells
2 name). I serve as Director of Ambulatory Services for
3 St. Anthony Hospital. Good afternoon, Mr. Chairman and
4 members of this Board.

5 CHAIRMAN GALASSIE: Good afternoon.

6 MR. HARRIS: Thank you for the opportunity to
7 be here today on behalf of St. Anthony Hospital, located in
8 the Lawndale community. I oppose this proposed project.

9 The umbrella of care that St. Anthony Hospital
10 provides derives straight from the voices of residents we
11 serve. This community is in need of a comprehensive
12 approach to both preventive proactive treatment,
13 especially when managing chronic kidney disease, and end
14 stage renal disease. The disproportionate number of
15 residents afflicted with obesity, hypertension, and
16 diabetes continues to rise and directly impacts the health
17 of this community.

18 DaVita's proposed outpatient dialysis center
19 does very little to address the holistic approach to
20 treating the entire disease and prevalent issues. These
21 issues include education on healthier lifestyle, diet
22 modification, and weight management, all of which help to
23 prevent families -- patients and families from becoming
24 susceptible to continuous, generational propensities. The

1 community will not benefit from another for-profit end
2 stage renal disease corporation entering this neighborhood.
3 This population does not need more of the same. Continuity
4 of care is essential in providing end stage renal disease
5 patients with support to navigate the healthcare climate.
6 Access to primary care physicians, nephrologists, diabetes
7 education and social services is vital to helping ensure
8 patients are compliant with demands of dialysis treatment.

9 On behalf of the residents of St. Anthony
10 Hospital community, we urge you to deny approval of this
11 proposed project. Thank you.

12 CHAIRMAN GALASSIE: Thank you very much,
13 gentlemen. We appreciate it. Again, my apologies.

14 (Pause)

15 CHAIRMAN GALASSIE: Have we sworn folks in?
16 They've been sworn in. Thank you very much. I apologize
17 for a little disjointedness in this application.

18 There are advantages and disadvantages to
19 public participation, and I think it only appropriate for
20 me, as Chair, to ask you just one question, and then we'll
21 have your presentation begin. There was an allegation of
22 corruption, and I don't feel it fair to simply leave that
23 in the air. I certainly have no knowledge of that.
24 Counsel has no knowledge of that. Could you just briefly

1 acknowledge -- are you aware of any allegations of
2 significant corruption with DaVita?

3 MS. DAVIS: CNN recently aired a grossly
4 one-sided story, recounting Medicare fraud allegations from
5 2007. The report contained false information about
6 DaVita's use in billing for medications. The issues
7 presented were taken out of context and ignored important
8 information.

9 Very briefly, back in 2007, the allegations
10 were brought against DaVita in Georgia. The Government
11 investigated, fully investigated. We worked hand in hand
12 with them, providing them everything they needed. At that
13 time, the Government decided that we had, indeed, followed
14 their practices. We had specifically gone to the
15 Government, to CMS, to make sure that we were following the
16 right protocols, and they said we were. They chose not to
17 follow up on those allegations and to go no further with
18 the case.

19 This is simply a matter of two whistleblowers
20 who are looking to gain in a situation where the Government
21 has chosen not to move forward. So, we are thoroughly
22 vetted on this.

23 CHAIRMAN GALASSIE: Thank you for your
24 comments and clarifications. Comments for the Board.

1 Let the record show David Carvalho has stepped
2 out of the room. He stepped into the back and now he's
3 out.

4 Go right ahead.

5 MS. FRIEDMAN: Did you want Mike to do the
6 Staff report, or should we go ahead?

7 CHAIRMAN GALASSIE: Yes, Mike. We're going
8 to get something right on this application before it's
9 over. I promise.

10 MR. CONSTANTINO: The applicants are proposing
11 to establish a 16-station ESRD facility in approximately
12 6,800 gross square feet of leased space in Chicago. The
13 cost of the project is approximately \$3.1 million. The
14 anticipated project completion date is March 31st, 2014.

15 Thank you, Mr. Chairman.

16 CHAIRMAN GALASSIE: Thank you, Mike.

17 Comments for the Board?

18 MS. DAVIS: Yes, I'd love to. Good
19 afternoon. My name is Penny Davis, and I'm the Division
20 Vice-President for DaVita in Chicagoland. With me today
21 are partners in this proposed facility, David Frankel,
22 representing Mount Sinai Hospital, and Dr. OGB Aneziokoro,
23 our Medical Director. Our legal counsel is Kara Friedman.

24 First, I'd like to thank the Board for taking

1 the time to hear this application, and specifically to
2 thank Dr. Burden and Courtney Avery for attending the
3 public hearing.

4 DaVita is a healthcare company with an intense
5 focus on kidney care, and because all we do is to provide
6 healthcare services, we understand how to obtain the best
7 outcome. In Illinois, there are nearly 18,000 patients
8 receiving dialysis. These are fragile patients, managing
9 three to five comorbidities, taking an average of eight
10 different medications, and with a 20 percent mortality rate
11 in their first 90 days of treatment. These are patients
12 who have to travel three times per week for dialysis
13 treatment that, on average, takes four hours. While we as
14 a company are focusing on education of pre-end stage renal
15 disease patients through local classes, one-on-one
16 education with patients and local nephrologists, and online
17 education, we know that 43 percent of patients had no
18 nephrologist when they started dialysis. It's our job not
19 only to provide excellent dialysis care, but the social
20 services and support that any patient new to this
21 life-sustaining care might need. We work hand in hand with
22 nephrologists in the community to provide options for the
23 type of dialysis, transplant, assistance in adapting the
24 lifestyle changes, nutrition education, monthly monitoring

1 of lab work, medication management, vaccinations, help in
2 finding transportation, and scheduling of appointments with
3 surgeons to ensure patients get a fistula in order to avoid
4 complications for catheters. We become the medical home
5 for most of these patients, who spend 12 to 15 hours a week
6 in our facilities.

7 We began serving the Lawndale community in our
8 Little Village facility seven years ago, and Mount Sinai
9 Hospital, our joint venture hospital for Lawndale dialysis,
10 has been providing dialysis services in that community for
11 50 years. The Little Village and Mount Sinai facilities
12 are full. Each are located approximately two miles from
13 the proposed Lawndale facility and serve patients who are
14 overwhelmingly African American and Hispanic. When it
15 comes to healthcare service access limitations, the City of
16 Chicago is unlike any other area in the state of Illinois.

17 One only need drive to the Lawndale community
18 to understand the poverty and challenges faced there.
19 Lawndale faces a number of health disparities and other
20 disadvantages in terms of access to care and economic
21 development. Chronic illness is prevalent in Lawndale.
22 Critical details of what is essentially a diabetes epidemic
23 were discussed by Sinai's Urban Health Institute
24 epidemiologists at our public hearing. The Institute's

1 work revealed that Lawndale has a 29 percent community
2 prevalence of diabetes. That's three and a half times the
3 national rate. The diabetes mortality rate in North
4 Lawndale alone is 62 percent higher than for the US and 37
5 percent higher than Chicago's diabetes mortality rate.

6 There is a stated 82-station need in the City
7 of Chicago, which is highest in the state. DaVita's 12
8 facilities in the City are collectively operating at 84
9 percent and leave little opportunity within the entire city
10 for dialysis patients who would choose to dialyze with us.
11 Utilizing a 30-minute normal travel time rule for patients
12 in this community simply does not speak to the harsh
13 realities for these patients. This rule would require
14 patients to leave not only their community but the city.
15 Many of these patients rely on public transportation, and
16 leaving the city would require transfer of buses. In
17 addition, for those who must rely on private transportation
18 companies that bill the healthcare system, the farther the
19 facility, the higher cost of the overall system.

20 The patients we seek to serve at this facility
21 overwhelmingly live within 10 to 15 minutes of the
22 facility. The project has received strong support from the
23 community at our public hearing. First of all, I'd like to
24 thank the alderman for his attendance and support, the

1 support of the neighborhood Federally Qualified Health
2 System Center, Lawndale Christian Health Center.

3 As we cited in our application, in your most
4 recently reported year, there has been an increase of more
5 than 175 patients receiving treatment for end stage renal
6 disease in the Service Area. Additionally, since we filed
7 the original application in October of 2011, one of the
8 area nephrologists has passed away, Dr. Lillian Magana.
9 All of Dr. Magana's patients in the area transferred to
10 Dr. OGB. A new facility would help ameliorate health
11 disparities and access issues for the large patient
12 population residing in this area, but also allowing many of
13 Dr. OGB's patients to be treated at just two facilities.

14 DaVita may be a large corporation, but I want
15 to address the community issue. Over the last year, local
16 DaVita teammates held a food drive and delivered over
17 10,000 pounds of food to the Greater Chicago Food
18 Depository. We provided weekend lunches to children who
19 participate in the school free lunch program and often have
20 no food on the weekends, in low-income Markham. We're
21 providing new coats to children both in the Chicago public
22 schools and in Markham. We provided free blood pressure
23 screening education, nutrition education in schools and
24 libraries. We provided blankets, towels, and toiletries to

1 teens through the Night Ministry program. We clearly are a
2 member of our community.

3 With the Board's inventory identifying a need
4 for 82 dialysis stations in the City of Chicago and in
5 consideration of the special needs of this very special
6 community, we ask that you approve this project. No other
7 community is more deserving of additional health services.

8 I'd like to turn it over to Dr. OBG.

9 MR. ANEZIOKORO: Good afternoon, ladies and
10 gentlemen. Thanks for having me today. I am
11 Dr. Aneziokoro, and I have served the Lawndale community
12 for going on six years. I'll be the Medical Director of
13 the proposed dialysis facility, and I thank you again for
14 the opportunity to explain why a facility is desperately
15 needed in this community.

16 Lawndale is a low-income, African American and
17 Hispanic community, located on the west side of Chicago.
18 Diabetes and hypertension are the two leading causes of end
19 stage renal disease in the United States. African
20 Americans and Hispanics have a higher incident and
21 prevalence than the general population. According to data,
22 Hispanics and African Americans are twice as likely to be
23 diagnosed with diabetes than the non-Hispanic whites, and
24 the rate of initiation of dialysis is 1.6 times in the

1 Hispanic population and 2.4 times the African American
2 population than in general population.

3 Diabetes is an epidemic in this community.
4 Lawndale has one of the highest rates in Chicago and I said
5 "twice", but three times the national average. This is
6 partially due to sociocultural factors, lack of access to
7 quality healthcare, and genetic makeup. Thus, establishing
8 a dialysis facility in this neighborhood and educational
9 and outreach programs will make a significant difference in
10 the lives of patients.

11 Additionally, it is more difficult for
12 patients without financial means to travel within the city,
13 let alone patients who are disabled. As a result, it is
14 important for these patients to be placed in facilities
15 close to their home. Unfortunately, those who serve this
16 community have not had the capacity for over four years.
17 It took me 52 minutes to drive 5.8 miles to see a dialysis
18 patient in that facility. That drive was 70 minutes from
19 the patient's house. I'm currently treating over 200
20 pre-dialysis patients who in the next 12 to 18 months will
21 require dialysis, and since, unfortunately, the passing of
22 Lillian Magana -- God bless her soul. She was my senior
23 partner. I'm the Medical Director of (unintelligible). I
24 already go to six different dialysis units in Chicago.

1 It's difficult, but I do it. And I found the patients --
2 like I said before, the patients don't trust the medical
3 community as they used to before. So, when you have
4 established the relationship, the patients feel the bond to
5 their doctor and it's difficult to tell them that, "Oh, I
6 can't see you in the dialysis facility because it's too far
7 away from where I go to."

8 I took an oath 18 years ago, when I became a
9 physician, to give selflessly and serve, and the last time
10 I stood before the Board -- this was in February -- I told
11 the story of a 70-year-old patient who (unintelligible),
12 who felt betrayed by me because I convinced him to get
13 dialysis. When he started dialysis, I more or less
14 couldn't see him in the dialysis facility. He since passed
15 away. I never got to treat him again, but his family still
16 calls me, and they seek my help and advice. Another
17 patient of mine, she started dialysis four months ago --
18 72-year-old Hispanic; she's paraplegic; and she comes to
19 dialysis once or twice a week, and most of my dialysis
20 patients need at least three times a week of dialysis, and
21 her reason is this: "It takes 40 minutes for my caretaker
22 to get me dressed, 30 minutes for the ambulance to get me
23 out of my house, and 35 minutes on a good day to get to a
24 dialysis facility, on the bad day over an hour. This is

1 why I come to dialysis once or twice a week." The winter
2 months are coming. I cannot guarantee that she will show
3 up for dialysis because of the snow coming up, and,
4 unfortunately, three or four months down the line RG is not
5 with us because we can't provide a dialysis center close
6 by.

7 I think this is why we're here today, no other
8 reason, for patients like RG, for Mr. Delgado, and the
9 Lawndale community, and that is the only reason we're here
10 today.

11 Finally, I have referred patients to the
12 DaVita facilities for six years. This is a competent
13 (unintelligible) services, and DaVita, with physicians like
14 me and other physicians, are continuously inventing new
15 programs to raise the standard of care, reduce healthcare
16 costs, and improve access to care of patients.

17 Thank you this time around, and I hope the
18 Board will approve this project.

19 CHAIRMAN GALASSIE: Thank you, Doctor.

20 MR. FRANKEL: Good afternoon. My name is
21 David Frankel, representing Mount Sinai. Since its
22 founding in 1919, Mount Sinai Hospital has been a safety
23 net for his community, caring for underserved populations
24 living in the state's most challenging neighborhoods. With

1 over 300 beds, we provide core tertiary care services,
2 including trauma and specialty care for neonates and
3 children, inpatient medical/surgical and psychiatric
4 services. Last year, 58 percent of our inpatients received
5 Medicaid benefits or charity care. In the last reported
6 period, our charity care expense alone was over \$19
7 million, well more than three times what St. Anthony
8 Hospital reported for the same period.

9 In these challenging financial times, we
10 continue to focus on elevating quality while emphasizing
11 the hospital's dedication to the communities we serve.
12 Sinai is on the path to achieve our vision of becoming the
13 national model for the delivery of urban healthcare. This
14 partnership is consistent with this goal.

15 Sinai believes that community-based healthcare
16 begins with pre-primary care, an ongoing community-based
17 initiative that goes beyond healthcare services and the
18 four walls of the hospital, to prevent disease and keep the
19 community healthy. The two main components of the Sinai
20 pre-primary care model the Sinai Community Institute, a
21 community outreach organization offering a broad array of
22 social services, and Sinai Health Institute, which
23 identifies health disparities and develops programs to
24 address these disparities.

1 Sinai Community Institute has grown to
2 represent 25 unique community programs. Patterned after
3 the life cycle of an individual, we start with pregnant and
4 parenting teens and continue with after-school programs,
5 work force development, elder abuse prevention programs,
6 and senior citizen support. Our Urban Health Institute's
7 vision is to serve as a leading urban health research
8 institute for eliminating health disparities and working
9 toward health equity. Its mission is to develop and
10 implement effective approaches that improve health of urban
11 communities through data-driven research, evaluation, and
12 community engagement. A major component of SUHI's work
13 involves examining the impact of social issues, such as
14 poverty, on health. SUHI focuses on its work on
15 eliminating health disparities in five key areas: Asthma,
16 breast cancer, diabetes, obesity, and smoking prevention.

17 SUHI has done the largest door-to-door health
18 status survey ever conducted in Chicago, and is creating
19 community-based interventions based on the survey results.
20 Our block-by-block diabetes program is one of these
21 initiatives and ties closely with the care we provide our
22 patients with renal failure. We are increasing the early
23 detection of diabetes and improving self-management by
24 diabetics. It is a neighborhood engagement approach to

1 reduce the impact of diabetes on the lives of thousands of
2 adults living in the Lawndale neighborhood.

3 Diabetes is at epidemic levels in this
4 community, and until we can reverse the underlying trends
5 that are creating this epidemic, the community needs more
6 end stage renal disease services. Our view is that
7 additional services are necessary, is consistent with the
8 ESRD need figures for the City of Chicago, which faces the
9 highest incidence rates in the state. As an institution,
10 we believe that the best use of our resources places the
11 operation of additional dialysis services within the joint
12 venture partnership that we have built with DaVita. We are
13 uniquely positioned as a dialysis provider in this
14 community. We are the only private, non-profit
15 hospital-based adult dialysis program in our Service Area
16 and nearly the only one in the City of Chicago. That
17 places us at a special vantage point to this project. We
18 treat the whole patient -- in fact, the whole person. We
19 are confident that as we integrate this new dialysis center
20 with our organization, it will help us to enhance the
21 continuum of care that we pride ourselves on.

22 Please grant us approval to establish this
23 outpatient dialysis center, which will be a great benefit
24 to an underserved community. Thank you.

1 CHAIRMAN GALASSIE: Thank you. I think your
2 last paragraph was probably the most compelling of your
3 comments.

4 Are there any questions from Board members?
5 Member Sewell, and then Dr. Burden.

6 MR. SEWELL: Yes. In the State Agency Report
7 on Table Five, we see facilities that are within 30 minutes
8 of your proposed site, and a great number of them have not
9 met the occupancy -- the utilization standard. So could
10 you comment on that?

11 MS. DAVIS: I would be happy to. Two of those
12 facilities are pediatric only, one being our children's
13 dialysis center at Children's Memorial; the other one being
14 at Rush. Others are just growing in terms of from the time
15 that they opened. Even when you look at Cook County -- I
16 recently met with Cook County Hospital. Up until recently,
17 they reported about 166 percent occupancy. They were
18 providing care for their chronic patients in Cook County.
19 Now they're trying to utilize their facility only for their
20 acutes, and so that's why their number has dropped.

21 To explain -- when I say "acutes", Cook County
22 has patients within the hospital that require dialysis
23 services. Those patients are being treated in their
24 stations and so, they're overwhelmingly using it for

1 in-patient services.

2 The other facilities might be for-profit or
3 independently owned, and we can't speak to their ability to
4 take patients without regard for ability to pay. Dr. OGB,
5 as he mentioned, is going to a lot of facilities now. The
6 patients that we propose for this center are patients that
7 specifically are Dr. OGB's, and so for him to go to another
8 center that's not -- that may be listed on here would be
9 detrimental to him and to his patients, if he can no longer
10 follow them.

11 MS. FRIEDMAN: And Mike correct me, maybe. U
12 of I Hospital is listed as having no utilization, but I
13 think that's just because they haven't reported.

14 MR. CONSTANTINO: Yes. The U of I Hospital
15 did not report, along with Loyola Dialysis Center in
16 Maywood did not report to us, and neither did Rush
17 University, on the survey we did of the dialysis facilities
18 in the state.

19 CHAIRMAN GALASSIE: Other questions from
20 Board members? I think Dr. Burden had one.

21 MR. BURDEN: It's perhaps a non-issue,
22 Mr. Chairman. I would like to ask whether you feel that
23 the answer to the question of alleged corruption has been
24 totally answered by a DaVita employee. I had no idea about

1 this. Maybe it is alleged and it is unnecessary to bring
2 it -- to return to it, but it's on my mind, if it is
3 something that we should know about. I know nothing about
4 it. I presume that others on the Board are comfortable
5 going ahead, without having any formal response to an
6 alleged corruption in another state. I just ask the
7 question.

8 CHAIRMAN GALASSIE: I think I have to ask
9 counsel to give us some recommendation if we should go any
10 further on this. The allegation was made. I felt there
11 had to be some ability to respond to that. I personally am
12 not sure we should go any further with this, but I think
13 that's my conscience.

14 MR. URSO: Well, I think if other Board
15 members feel that there are some unanswered questions here,
16 then the Board has the prerogative to either ask the
17 applicant, since we are still within the time frame, to
18 seek a deferral, or the Board can get its own deferral, if
19 the Board would like for us to look at these allegations.

20 CHAIRMAN GALASSIE: You're suggesting the
21 Board might move to defer this project pending Staff
22 investigation into some additional information on these
23 allegations?

24 MR. URSO: We would try to get you some more

1 information, because the only information we received thus
2 far is from public comment and then the applicant. If you
3 want the Board Staff to do an independent review --

4 CHAIRMAN GALASSIE: We're not asking for
5 response. This is Board dialogue right now.

6 MR. URSO: If the Board would like Board Staff
7 to do an independent review, we will, of course, do that.

8 CHAIRMAN GALASSIE: What I'm going to do at
9 this point -- I'm going to ask for a show of hands. Are
10 you comfortable in moving forward with a vote on this? And
11 the other question will be, do you prefer to defer this,
12 pending additional information?

13 Show of hands for those who would desire to
14 move forward with it.

15 (Raising of hands)

16 MR. URSO: Let the record reflect who those
17 hands are: Mr. Hayes, Ms. Olson, Mr. Sewell, Mr. Bradley,
18 and Justice Greiman.

19 CHAIRMAN GALASSIE: And the Chair.

20 MR. URSO: And the Chair have raised their
21 hands.

22 CHAIRMAN GALASSIE: We will move forward.

23 Are there any other questions from Board
24 members for the applicants?

1 MS. OLSON: I have a quick question. I don't
2 see OSF on this list anywhere. Am I not reading it
3 correctly? The gentleman talked about the negative impact,
4 and I don't see them on the list.

5 MR. CONSTANTINO: You're talking about St.
6 Anthony?

7 MS. OLSON: Yes.

8 MR. CONSTANTINO: They're coming to the Board
9 February 5th. They submitted an application.

10 MS. OLSON: So they don't have a dialysis --

11 MR. CONSTANTINO: No, they don't have a
12 dialysis facility, and I don't believe it's an OSF
13 facility.

14 CHAIRMAN GALASSIE: I'm going to move us
15 forward for a vote, following Mr. Penn's question.

16 MR. PENN: Table Four, if I'm reading this
17 correctly, charity care, 2009, '10, '11 -- seems to be a
18 net revenue increase each year but a decrease in charity
19 care. Is this correct?

20 MS. DAVIS: The Medicaid and Medicare
21 combined, Medicaid is actually going up. All patients in
22 the state of Illinois are eligible for Medicaid or
23 Emergency Medicaid, and we've actually been able to get
24 those patients onto Medicaid sooner, and so it's less need

1 for charity care.

2 MR. PENN: Less need of charity care in this
3 area we discussed for this application?

4 MS. DAVIS: Yes, because, actually, those
5 patients are covered under Medicaid. It's not that we're
6 doing fewer number of patients, providing charity care to
7 fewer. It's that they're getting some form of payment
8 reimbursement, either from Medicaid or Medicare.

9 MR. PENN: But some of them are not qualified
10 for Medicaid, and you're asking them to apply for funding
11 through the American Kidney Fund.

12 MS. DAVIS: Yes. If they --

13 MR. PENN: So there are some that aren't
14 qualified for Medicaid?

15 MS. DAVIS: Right. Any patient who has no
16 financial assistance, whether it be Medicare, Medicaid, the
17 Kidney Foundation, those patients we continue to take care
18 of, regardless of ability to pay.

19 MS. FRIEDMAN: If I might, those patients who
20 get grants are usually people who actually do have assets
21 and are uninsured and they're spending down their assets,
22 and once you're medically indigent, then you will qualify
23 for Medicaid.

24 MR. PENN: And then my -- okay. I'm not sure

1 if I follow that. The percentages of charity care is going
2 down.

3 And the other thing about time it takes to
4 building this facility. In looking at this, you're a
5 free-standing building for remodeling. You're going to
6 take 15 months to build. We just saw a previous
7 application that's going to take four to five months. I'm
8 always concerned about, you know, the possibility of trying
9 to lock up a market, keep competitors out by extending your
10 time to build.

11 MS. DAVIS: We've actually taken the risk
12 already to start construction drawings. Because of the
13 fact that the City of Chicago -- the permitting process
14 takes so long, we've had other just simple, simple
15 remodeling projects where the time to permit takes anywhere
16 from three to four months. So, we make sure that we add
17 that time in.

18 MR. PENN: That's -- the last applicant said
19 they would complete in maybe three, four, possibly five
20 months.

21 MS. FRIEDMAN: I think we take special
22 consideration for timelines in the City of Chicago, because
23 their permitting process are the most difficult in the
24 state, probably in the country.

1 MS. DAVIS: And you actually can't talk to a
2 person in the Permitting Department.

3 CHAIRMAN GALASSIE: I'm going to actually
4 call for a motion, if I may. Pardon me.

5 May I have a motion to approve Project 12-085,
6 DaVita Lawndale Dialysis, authorizing the establishment of
7 a 16-station ESRD station in Chicago, Illinois?

8 MR. BRADLEY: So moved.

9 MR. HAYES: Second.

10 CHAIRMAN GALASSIE: Moved and seconded.

11 MR. ROATE: Motion made by Mr. Bradley,
12 seconded by Mr. Hayes.

13 Mr. Bradley?

14 MR. BRADLEY: I'm going to vote yes on this,
15 because I think our criteria regarding time -- not as to
16 how long it takes to build, but how long it takes to get
17 places -- certainly is a difficult issue in the City of
18 Chicago. This chart shows that you can get to Lincoln Park
19 in 30 minutes from Lawndale. You can't. I lived in the
20 North. I couldn't get to Lincoln Park in 30 minutes. This
21 shows that you can get to North Center in 30 minutes from
22 Lawndale. North Center is way north of Lincoln Park. You
23 can't get there in 30 minutes. And those are just the
24 physical traffic kind of barriers. There are also ethnic

1 barriers and economic barriers which lock people into the
2 neighborhoods of Lawndale and make it impossible for them,
3 in their mind at least, to travel into areas like Lincoln
4 Park, North Michigan, and areas where -- places like
5 Northwestern are. I think at some point, we need to take a
6 look at this entire criteria and how it applies. So I vote
7 yes on this.

8 MR. ROATE: Dr. Burden?

9 MR. BURDEN: I agree that the travel times are
10 an issue and the whole thing should be looked at, but I'm
11 still going to vote no, based on Planning Area need and
12 unnecessary duplication.

13 MR. ROATE: Thank you.

14 Senator Demuzio?

15 MS. DEMUZIO: Yes.

16 MR. ROATE: Justice Greiman?

17 MR. GREIMAN: Yes. I'm going to vote yes,
18 because the statistics are not meaningful. You have to
19 know the area and look at the people who live there. You
20 have to look at how they suffer in many ways living there,
21 and mere statistics are meaningless. So I vote yes.

22 MR. ROATE: Mr. Hayes?

23 MR. HAYES: I'm going to vote yes because of
24 the similar things with the distance and also the

1 partnership with Mount Sinai Hospital.

2 MR. ROATE: Ms. Olson?

3 MS. OLSON: I'm going to vote yes, based on
4 the patient population and the special group.

5 MR. ROATE: Mr. Penn?

6 MR. PENN: No; duplication of services.

7 MR. ROATE: Mr. Sewell?

8 MR. SEWELL: No; Planning Area need and
9 unnecessary duplication.

10 MR. ROATE: Chairman Galassie?

11 CHAIRMAN GALASSIE: No, based on comments
12 previously made.

13 MR. ROATE: That's five in the affirmative,
14 four in the negative.

15 CHAIRMAN GALASSIE: Motion passes. Good luck.

16 Just to remind Board members, while you always
17 have the right, too, if you so choose, to vote yes, you do
18 not necessarily have to give an explanation. Counsel does
19 wish for explanation when there is a "nay" vote.

20 Moving on, we have one public participation
21 request for the Chicago Surgical Clinic.

22 We're going to take a short break for the
23 Court Reporter. When we return, we'll be calling up
24 Ms. Curth.

1 (Recess)

2 CHAIRMAN GALASSIE: Okay. We'll come back
3 from the recess for public comment.

4 Introduce yourself, and spell your name for
5 the record.

6 MS. CURTH: Good afternoon Chairman Galassie
7 and members of the Board and Staff. My name is Nicolette
8 Curth (spells name). I'm from Presence Health, and I'm
9 here to testify in opposition to Chicago Surgical Clinic,
10 Limited.

11 Presence Health sent an impact letter, stating
12 not only that our facilities have the capacity to
13 accommodate the procedures projected for this proposed
14 facility, but that currently, the physicians who are the
15 applicants are performing a significant number of
16 procedures at three of our hospitals. Then, at the public
17 hearing, I testified about the lack of charity care
18 projected for this facility. In compliance with the
19 Planning Board's rules, I'm not here to repeat that
20 testimony but to inform the Board of some additional
21 information.

22 As the Board may recall, Presence Health has a
23 multi-specialty ASTC at Belmont and Harlem in Chicago,
24 which is a joint venture with a number of physicians. This

1 ASTC is among the large number of under utilized facilities
2 in the area. Over the last couple of months, Presence'
3 leadership has been meeting with Dr. Levitin regarding our
4 surgery center. We have offered her the opportunity to
5 become an owner/member of the surgery center, thus allowing
6 her to provide the high quality, low-cost surgical services
7 that she desires for her patients without exacerbating the
8 current under utilization of existing facilities.

9 Unfortunately, however, we have not heard anything back
10 from Dr. Levitin since the meetings, and, as witnessed by
11 the fact that she is here to come before you for her own
12 ASTC today, it's obvious that our offer is not her choice
13 at this time.

14 I anticipate that Dr. Levitin will tell you
15 that our ASTC is not in the best location for her patient
16 population. However, at the public hearing, she and her
17 supporters testified again and again that Dr. Levitin's
18 patients come from all over the city metropolitan area.
19 Multiple persons testified that these patients come to
20 Dr. Levitin not because she's close to their home, but
21 because she is Russian speaking. So, Russian people in
22 Chicago, many of whom do not speak English very well, will
23 travel long distances to see her. In her meetings with
24 Presence leadership, Dr. Levitin confirmed this, stating --

1 and I quote -- "The patients will follow the doctor."

2 So, in conclusion, let me reiterate that
3 there is no need for Dr. Levitin to establish a new ASTC.
4 Presence Health continues to offer her a much better
5 solution, a solution that will provide her patients
6 convenient, high quality, low-cost surgical services, while
7 utilizing existing OR capacity, rather than increasing the
8 current over-capacity and costs in the Chicagoland health
9 system.

10 So we hope, Doctor, you will change your mind
11 and come with us.

12 Thank you.

13 CHAIRMAN GALASSIE: Thank you.

14 Will the representatives from Chicago Surgical
15 please come up.

16 MR. CONSTANTINO: Mr. Chairman, we received
17 comments on the State Agency Report -- State Board report
18 that were distributed to you. I've got more copies here
19 today, if you'd like for me to distribute them.

20 CHAIRMAN GALASSIE: We received comments.
21 They've been distributed to Board members.

22 Also, for the record, Member Penn has left for
23 the day.

24 MR. URSO: Mike, these comments are responsive

1 and they're timely?

2 MR. CONSTANTINO: Yes.

3 CHAIRMAN GALASSIE: So, the Board has to
4 determine if you want to accept these comments or not.

5 MS. OLSON: So moved.

6 MR. SEWELL: Second.

7 CHAIRMAN GALASSIE: Moved and seconded. All
8 in favor?

9 ("Ayes" heard)

10 CHAIRMAN GALASSIE: Any opposed:

11 (No response)

12 CHAIRMAN GALASSIE: Hearing none, thank you.
13 If you would, please introduce yourselves,
14 spell your name, and we'll get you sworn in.

15 MR. CARROLL: Thank you, Mr. Chairman. I'm
16 Howard Carroll (spells name). I'm the attorney for the
17 Chicago Surgical Center and also for Dr. Levitin.

18 MS. LEVITIN: I am -- my name is Yelena
19 Levitin (spells name), and I'm the owner of the proposed
20 project.

21 MR. KIRK: Robert Kirk (spells name), Group A
22 Architecture.

23 MS. PAIGE: We are Billy Paige and Ira Rogal
24 from Shea, Paige and Rogal. We are CON consultants.

1 CHAIRMAN GALASSIE: Thank you very much.

2 Staff report?

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

4 The applicants are proposing to establish an
5 ambulatory surgery treatment center, a multi-specialty
6 ambulatory surgical treatment center, in Arlington Heights.
7 The estimated cost of the project is approximately \$3.9
8 million. The anticipated completion date is April 30th,
9 2013.

10 Thank you, Mr. Chairman.

11 CHAIRMAN GALASSIE: Thank you.

12 Comments for the Board?

13 MR. CARROLL: Are you ready for us?

14 CHAIRMAN GALASSIE: Yes.

15 MR. CARROLL: Thank you, Mr. Chairman. I want
16 to thank Dr. Burden and Ms. Avery for attending and
17 participating in the public meeting. As I indicated, I'm
18 Howard Carroll. I represent the organization seeking this,
19 and there are some unique things about this, contrary to
20 the last person who testified.

21 Yes, it is something that is very much needed.
22 We are a very underserved community in the Russian-speaking
23 population, which not only includes those who came out of
24 the former Soviet Union, but all of those surrounding

1 countries who learned how to speak Russian because of the
2 nature of business in that community, in that part of the
3 world, whether it was Latvia, Lithuania, Poland, et cetera.
4 According to testimony that was brought before the public
5 meeting from the Russian newspaper publication, there are
6 450,000 people in that part of our region -- they didn't
7 identify specifically where -- who are Russian speaking and
8 have problems with other languages. The other facilities
9 around, as we just heard, do not have the ability to
10 provide services to that population, because they don't
11 have people on staff who speak, understand, and communicate
12 in Russian. The same is true of some of the other minority
13 populations that Dr. Levitin has already served.

14 This population has other problems. One is
15 the fact that many of them are uninsured or under insured.
16 Many of them need some type of charity care, some type of
17 Medicaid, and the institutions in that community who
18 appeared at that public hearing do not provide that. Their
19 numbers are extremely low, what they currently provide in
20 Medicaid coverage, in charitable care, and in uncompensated
21 care. For example, Dr. Levitin in her proposal will be
22 providing -- 7.2 percent of the income will be coming from
23 Medicaid. She expects that 5 percent will be from
24 self-pay. Self-pay does mean, by the way, that they're not

1 paying anywhere near what they are being charged to go
2 anywhere else. And then they will have 3 percent charity
3 care. The other institutions there average less than
4 one -- within the 1 percent to 2 percent range, whether it
5 was charity care, Medicaid, or self-pay.

6 The numbers that were presented at that
7 hearing showed a huge difference between what the Northwest
8 Community Hospital system and the Providence Hospital
9 system charge to the patients for simple procedures that
10 can be done in an outpatient setting, and they have their
11 own outpatient settings. On the average -- and I can give
12 you exacts, if you would like it. On average, the surgery
13 center, the Chicago Surgery Center will be charging
14 approximately 20 to 30 percent of what the charges have
15 been at these other institutions. So, it's not just a
16 matter of location. And, yes, Belmont is pretty far away.
17 But it's not just that. It's what they charge, and those
18 who were there heard the testimony that you have from those
19 hearings, and it will show you the number of people --
20 doctors -- the doctor who was the Chairman of the
21 Russian-Speaking Doctors Association, other doctors who
22 refer now to Dr. Levitin, all talked about the fact that
23 that's the only place they can go where their patients can
24 get services at a reasonable price and at hours that are

1 not available to them at these other institutions. For
2 example, she works at night. The people who work with her,
3 the other doctors, work at night. She works on weekends.
4 The people who are with her work weekends. You can't get
5 those procedures as a -- in the surgical center at the
6 hospital settings. So not only are they two to three times
7 more expensive, they're not available.

8 They had a Russian-speaking student, college
9 student, who speaks English, but basically Russian is his
10 language of choice. He had come in with an abscess -- a
11 cyst, if I'm correct. He was quoted a number of something
12 like \$2,000 to have it done at one of those institutions.
13 He's a student. He's barely able to pay his tuition. He's
14 working when not in school in order to pay part of a shared
15 room and eat. He couldn't afford that. He came to her --
16 and he also couldn't come during the day without cutting
17 school. None of us what want him to cut school. None of
18 us did that -- well, I take that back. Strike that. But
19 her charge was a little over \$200, and on a weekend.

20 That's what the Certificate of Need is.
21 That's where the need is. Need is for people to get
22 services when they need them.

23 Another person testified at that hearing about
24 how he had to avoid getting service for years because he

1 couldn't afford it at any of these hospitals, until it got
2 to the point that he was so sick that he had to be taken
3 from the northwest suburbs to County Hospital to get the
4 procedure performed that could have been performed much
5 less expensively, in a timely fashion, where the person
6 would have been healthier at her facility. Now we all pay
7 for it -- not those of you from downstate, but those of us
8 in Cook County paid for it, because it was in our tax
9 bills. That's not needed.

10 So, if we're going to look at this from the
11 standpoint of where is the need, where is the need and
12 where is it being served, this is where it will be served
13 at. She has other doctors who are joining her, who will be
14 charging the same as she is charging and providing those
15 same kind of services to people most in need. Even when
16 Northwest Community, which didn't come here today -- and
17 you have this in the record -- showed how little they
18 actually spent -- in fact, for 2011, according to the
19 records they presented, they didn't spend a dime -- I'm
20 sorry. They didn't receive a dime or even a penny in
21 Medicaid payments. Likewise, they presented less than 1
22 percent in charity care. That's not what this is supposed
23 to be about. That's not why a Certificate of Need was
24 created. This is the type of place that will perform those

1 kinds of needs.

2 Let me add kind of a personal item for you and
3 then turn it over to the good doctor. Years ago, some of
4 you may remember, there was a law passed that required
5 every institution, every medical institution, every
6 hospital to post in their admissions area the 10 most
7 common procedures and what the charge would be, and when we
8 were -- when I wrote that, the hospitals were coming in
9 saying, "I give free phone" and "I give free television".
10 I said, "Do like the car places do, the manufacturers. Put
11 it on the window. Everybody has got to be able to see it."
12 And I must say, after I retired, I was very proud to see
13 that in hospitals in my area when I walked in. Suddenly
14 they disappeared. Somebody has amended the law at some
15 point, with probably nobody paying attention to it, and
16 eliminated that section; and I don't know if you have the
17 authority to, but I think it would be appropriate for a
18 board like this to offer that type of legislation to the
19 General Assembly, to say that that would help people a lot
20 to know what they're going to pay before they walk in.

21 Again, there were people who testified as to
22 that, that they walked in expecting to pay so much --

23 CHAIRMAN GALASSIE: Has this got to do with
24 Chicago Surgical?

1 MR. CARROLL: Yeah, because Chicago Surgical
2 charges what people can afford, and when they can't, they
3 either give it away -- they pay personally -- or they
4 accept the Medicaid that others don't or they give them
5 charity care.

6 CHAIRMAN GALASSIE: All right. Thank you.
7 Doctor?

8 MR. LEVITIN: Yes. Thank you again for giving
9 me the opportunity and the privilege of addressing you
10 today. I am here on behalf of my patients and community
11 that I serve. I've been in practice for over 12 years.
12 I'm a graduate of Northwestern University Medical School,
13 and I've been dealing with these issues for a very long
14 time.

15 Over the years, I have been seeing a large
16 percentage of under insured or uninsured people who
17 desperately need affordable and expeditious surgical
18 services. The numbers of these in need are rising
19 dramatically. This is why I am here today. A large
20 percentage of our patients are not able to afford their
21 much-needed procedures at the existing facilities, in view
22 of the high cost and limited accessibility.

23 We are planning to conduct necessary services
24 at a more flexible schedule. We have always worked long

1 hours on the patients we have and will continue to do so.
2 A lot of my patients are working immigrants and are very
3 reluctant to take time off work. Providing evening and
4 weekend hours is invaluable to them. They will do whatever
5 it takes to keep their jobs and income. A lot of them are
6 working poor. Not all of them (unintelligible). We have
7 patients of all kind and walks of life.

8 The patients that are (unintelligible) in our
9 center are the ones that are avoiding coming to the
10 hospital. They often times must (unintelligible) the
11 required procedures, when they can do it on an elective
12 basis and avoid complications. Instead, they end up in the
13 ER's in the same area hospitals with surgical emergencies,
14 and it becomes more expensive for the hospitals, for the
15 taxpayers, for the patients itself.

16 My center is designed to avoid this type of
17 predicament. I will give you a couple of live examples.
18 For example, I have a 24-year-old immigrant from Eastern
19 Europe. She works in a factory. She has a breast tumor
20 that is rapidly growing. Most likely, the tumor is a
21 (unintelligible) tumor, so it has a potential to spread.
22 It has the potential to take over her breast. We've been
23 trying to find a facility where the tumor can be removed.
24 The lowest price that I was able to find was \$3,200 just

1 for the facility fee. That would not include the pathology
2 or the anesthesia fee. This is exactly the facility on
3 Harland that that woman was talking about. Before joining
4 the facility, I actually tried to find out what their rate
5 would be for my self-pay patient who needed the procedure.
6 So the rate they quoted was \$3,200, and they would not
7 negotiate. So, as a result, the lady keeps
8 procrastinating, the tumor might spread, she might need a
9 mastectomy and reconstruction. She might need
10 chemotherapy. Again, it's going to cost more to us as a
11 society and to her as a patient.

12 I have another patient, another young patient,
13 and a lot of my patients are young, working patients. He
14 has been having rectal bleeding for several months. He
15 might be harboring a malignancy, but the price at the
16 existing facilities for a life-saving colonoscopy are too
17 high for him to afford. So, he's been procrastinating as
18 well. All it would take is doing a colonoscopy and
19 probably removing a bleeding polyp, and that would save
20 society a huge amount of problems.

21 We have tried to send those people to Cook
22 County hospitals. I was trained at Cook County Hospital as
23 a resident, so I know how it works. Unless you're dying in
24 front of the hospital, you're not going to get care right

1 away. So, basically for lengthy procedures, the wait is
2 extremely long. Now the County Hospital is actually
3 charging the patients. So, they have a predicament and are
4 trying to help the ones that need it.

5 So, overall, the establishment of an
6 ambulatory surgical treatment center would benefit not only
7 patients but the healthcare system in general. It would
8 improve access to care and affordability. I'm in a unique
9 position to provide those services, because of my cultural
10 background and established position in the community. I'm
11 asking for your support in this vitally important
12 healthcare issue.

13 Thank you.

14 CHAIRMAN GALASSIE: Thank you, Doctor.

15 I'm going to open up to members of the Board
16 for questions.

17 MR. SEWELL: I guess this is more for
18 Mr. Constantino. It seems like a few meetings ago, I think
19 we talked about these specialty ambulatory surgery
20 treatment centers, and we don't have rules for them; is
21 that correct? We just have rules for general ambulatory
22 surgery treatment centers?

23 MR. CONSTANTINO: That's correct.

24 MR. SEWELL: So this -- if we had rules, this

1 would fit into a specialty ASTC? Because I'm seeing that
2 it's oral and maxillofacial and endoscopic.

3 MR. CONSTANTINO: We identify that as
4 multi-specialty.

5 MR. SEWELL: Which we do have criteria for?

6 MR. CONSTANTINO: Yes.

7 MR. SEWELL: I just wanted to be on the right
8 track.

9 I guess I would ask the applicant. What
10 happens now, when someone whose primary language is Russian
11 or one of the Russian languages? If they go to some of
12 these hospitals or some of these other ambulatory surgery
13 treatment centers, they don't have anything except the
14 example I think Senator Carroll gave that -- what was it, a
15 student interpreting? But they don't have systems for
16 languages, where it sounds like you have a substantial
17 population of people speaking this language. What do they
18 do about it?

19 MS. LEVITIN: It's not really the language
20 itself. The language is important because the patients
21 feel more comfortable with a physician that. Speaks their
22 language. It's more about financial affordability and the
23 flexible hours.

24 CHAIRMAN GALASSIE: Any provider receiving

1 federal dollars has to serve you in your language of
2 choice. So, they have to have a system in place. I agree
3 with the doctor that it's not always the most efficient,
4 but they have to have language capability.

5 Dr. Burden and Member Olson.

6 MR. BURDEN: Doctor, I just have a few things
7 I wanted to go over, one of which is not necessarily
8 germane just to you, but we just heard my fellow Board
9 member comment about evaluating multi-service ambulatory
10 treatment surgery centers and how we evaluate, shall we
11 say, performance or evaluate the outcomes. That's very
12 difficult, because we're looking at hours that fit -- the
13 number of hours that the room is used in ambulatory
14 surgical treatment center, to evaluate whether there is the
15 need in the Hospital Service Area for another one.
16 According to the document I have, which you have access to,
17 13 of the 16 ambulatory treatment surgery centers in the
18 area that we're talking about do not operate at the State
19 Board level. In other words, 80 percent of them, according
20 to this criteria, are not busy; but that to me is not very
21 helpful.

22 The amount of hours that are spent there are
23 only part of the issue for me to evaluate, and I'm looking
24 forward to getting an opportunity to have better criteria

1 to evaluate other ones that you're going to be competing
2 with and whether or not your presence alters or affects
3 their performance, which, of course, that would come under
4 the guise of where we are in order to prevent
5 maldistribution. So, I really don't know how to evaluate
6 what I see here. There are 4 of the 13 under performing,
7 ambulatory treatment centers that are newly established,
8 and hence we should throw them out. But we still have 9 --
9 over half of the ones that are in the area where you are
10 that are, quote, unquote, under performing by the standards
11 we currently have. The standard is how many hours is the
12 room in use. It's a very obtuse standard.

13 I spent 15 years looking at all of the alleged
14 malpractice in the County of Cook. We have a much
15 different standard to evaluate performance there, and that
16 record is clear. But this is obtuse to me. I can't tell
17 you how I feel, except if I look at this, I think there's
18 already too many ambulatory surgery treatment centers in
19 your area. Now, I'm not sure that affects anybody else and
20 their interpretation but mine, but that is what I suggest.
21 That is one question I have.

22 The other is I haven't had access to page 203,
23 where you list the procedures you will be doing. What --
24 can I briefly have you cover what maxillofacial procedures

1 you might be doing, or are you having a maxillofacial
2 surgeon, or are you Board certified in General Surgery, or
3 do you have a subspecialty? I don't know those things.
4 I'm just asking.

5 MS. LEVITIN: It's not going to me who is
6 going -- I'm not the one doing oral maxillofacial
7 surgeries.

8 MR. BURDEN: Are you a Board certified ENT
9 physician?

10 MS. LEVITIN: They're oral dentists.

11 MR. BURDEN: Oral surgeons. And the type of
12 endoscopic procedures -- do you do colonoscopy,
13 proctoscopy, gastroscopy? Are you the endoscopist?

14 MS. LEVITIN: Yes, I am doing the endoscopies,
15 lower and upper endoscopies.

16 MR. BURDEN: And you have Board certification
17 in endoscopy procedures, or are you simply a general
18 surgeon?

19 MS. LEVITIN: General surgery covers
20 endoscopic procedures. We have extensive treatment
21 training in endoscopy. It's part of my General Surgery
22 Board certification. I have performed multiple endoscopies
23 in training and performed multiple endoscopies in practice.
24 It's not a separate specialty. Most of the general

1 surgeons do endoscopies.

2 MR. BURDEN: I'm not disputing that. I'm just
3 asking about what the numbers of procedures that are done
4 by the members of -- how many people are going to be
5 involved in your multi-specialty practice?

6 MS. LEVITIN: You know, I have interest
7 expressed by a lot of physicians other than my own group.

8 MR. BURDEN: So you would have other people
9 applying to this that we don't know about, or do you have?

10 MS. LEVITIN: My group consists currently of
11 myself and my partners, but I do have interest from other
12 physicians.

13 MR. BURDEN: I'm just curious, because I think
14 the amount of time that you would expect to satisfy our
15 criteria would be accomplished by X number of physicians.
16 Obviously, the minimum amount is considered to be 1,500
17 hours per room for a year. That's the criteria that we use
18 now. That may not be valid in the long run. I'm looking
19 at other criteria, but that's what the -- that's the one we
20 have already. So, my question being, in order to
21 accomplish that goal, you're going to need more than
22 yourself. Am I right or wrong? You've got an ENT person,
23 an oral person, an endoscopist. Are all of those items
24 covered by you?

1 MS. LEVITIN: I have myself, my two partners,
2 I have an oral surgeon, and since we are providing a much
3 more payment structure, much more flexible hours, I have a
4 lot of interest expressed from several of other
5 specialists. I have a urologist who is interested. I have
6 a gynecologist who is interested. I have a plastic
7 surgeon. So all those people that have ascribed to the
8 same model would be interested to come and provide
9 services. And, besides that, we have a huge percentage of
10 the patients right now that are underserved. They don't go
11 to the surgical treatment centers in the area. They cannot
12 afford it. They are lining up and waiting for somebody to
13 be able to take care of them.

14 MR. BURDEN: Mr. Constantino, assume we
15 approve this application. Is it appropriate for our
16 approval to include the distinct entities that are going to
17 be performed at the institution? Isn't that correct?

18 MR. CONSTANTINO: That's correct.

19 MR. BURDEN: So that if she, the doctor,
20 wishes -- excuse me, Doctor. If you wish to bring in other
21 services -- she has to return to us. You mentioned
22 urology, whatever -- I'm a urologist -- neurology,
23 whatever, people that evaluate inter-cranial disease.
24 These issues have to come back to us in order for you to

1 meet this criteria, this particular discipline.

2 Am I correct on that?

3 MR. CONSTANTINO: You have to condition the
4 permit to do it.

5 MR. BURDEN: So right now we're approving
6 General Surgery, Endoscopy and Oral Surgery.

7 MR. CONSTANTINO: Right, and then you'd have
8 to condition the permit to state that if any additional
9 surgical procedures are added, they'd have to come back
10 before the Board for approval.

11 MR. BURDEN: Do you understand that, Doctor?

12 MR. CARROLL: Yes, she does.

13 MR. BURDEN: Thank you.

14 CHAIRMAN GALASSIE: If I may ask, help me
15 understand. I have Public Health background and community
16 health background. Why wouldn't some of the patients
17 you're describing go to a Cook County community health
18 center who has referral procedures to Cook County or cover
19 Cook County hospitals?

20 MS. LEVITIN: Well, you would have to actually
21 live that situation to understand it. It's an extremely
22 difficult situation to be in. In order to get anything
23 done at Cook County Hospital, it takes months, if not
24 years. The access is the problem. They have limited

1 resources. They're not -- there are so many uninsured and
2 under insured people that they're not able to service all
3 of them. They can only service the sickest ones of them,
4 and, again, a lot of my patients, they're working poor.
5 They cannot take the whole day off work to sit in the line
6 in the clinic to register for that appointment with the
7 primary care doctor. The way things work, you can't get to
8 see the surgeon right away. As I said, I did part of my
9 training at Cook County. You have to go see the primary
10 care doctor. The primary care doctor determines you might
11 have a surgical condition. Then you are referred to the
12 surgical clinic, spend hours sitting in line there. You're
13 seen by the first-year resident, who might then talk to the
14 attending, and you might get in and get scheduled for
15 something a few months down the line. And then you get
16 canceled multiple times, because the operating rooms are
17 not available. I've been in that situation multiple times.

18 MS. OLSON: I can actually tell you from
19 personal experience, I've lived that as well, when trying
20 to refer oral surgery patients who are under insured in
21 Illinois. They say they'll take them at UIC, but --

22 CHAIRMAN GALASSIE: Doc, do you mind if I move
23 us along?

24 MR. BURDEN: I just want to add one thing and

1 I will be quick, I hope. I do understand what you said. I
2 dispute the fact that it's interminable and have limited
3 resources. I believe County does an outstanding job. I
4 don't deny -- having been there and worked there long
5 before you were even on the scene -- it wasn't very
6 efficient, but there are institutions around where your
7 patients can be cared for. You make it sound like we're a
8 Third World country. Not true. We have hospitals that
9 take care of any number of uninsured patients, by law. I
10 practiced for 45 years. I was the Head of Urology at
11 Children's Hospital. I can tell you there were many
12 congenital anomalies where there was no coverage, but we
13 took care of them and still do.

14 CHAIRMAN GALASSIE: I'm going to move us
15 to -- may I have a motion to approve Project 12-076?

16 MS. OLSON: I just had a comment, because I do
17 understand your model, what you're trying to do, and I
18 really applaud it, because I have lived in the situation
19 where you cannot refer people and they just don't get care.
20 But I wondered -- and I hope these figures are right. You
21 said 3 percent charity, 7.5 percent Medicaid and 5 percent
22 self-paid.

23 MS. LEVITIN: That's right.

24 MS. OLSON: I'm wondering if you would be

1 willing to have that as a condition of approval of your
2 permit, that you would strive to achieve those numbers or
3 get as close to those numbers as you possibly can.

4 MS. LEVITIN: Definitely. That's what we're
5 doing right now.

6 MS. OLSON: So I would ask in a motion that we
7 could include that.

8 CHAIRMAN GALASSIE: I'll make the motion and
9 then you can verbalize the friendly addition.

10 MS. OLSON: I just want to make sure I have
11 those numbers right.

12 MR. CARROLL: That's correct.

13 CHAIRMAN GALASSIE: May I have a motion to
14 approve Project 12-076, Chicago Surgical Clinic, Limited,
15 authorizing the establishment of a multi-specialty ASTC in
16 Arlington Heights, Illinois, with the condition that the
17 applicant agrees to strive towards meeting --

18 MS. OLSON: -- Towards meeting a historical --
19 meeting or exceeding a payor mix of charity, Medicaid and
20 self-pay.

21 CHAIRMAN GALASSIE: And you had some numbers
22 there.

23 MS. OLSON: But you don't want the numbers in
24 there?

1 CHAIRMAN GALASSIE: Meet or exceed the
2 historical payor mix.

3 MR. BURDEN: Mr. Chairman, I want to add also
4 to that, that if there is additional certified,
5 Board-certified --

6 CHAIRMAN GALASSIE: Folks, I got too many
7 people talking in my ear.

8 MR. BURDEN: I mentioned it earlier. I wanted
9 to remind you that they should be in the proposal, that if
10 other surgeons are brought on board, other than the
11 specialties we've approved, they come in front of us.

12 CHAIRMAN GALASSIE: They have to.

13 So let me just reiterate again. I apologize.
14 May I have a motion to approve Project 12-076, Chicago
15 Surgical Clinic, Limited, authorizing to establish a
16 multi-specialty ASTC in Arlington Heights, Illinois, with
17 the contingency that they -- the applicant agrees to meet
18 or exceed historical payor mix.

19 MR. CONSTANTINO: Mr. Chairman -- go ahead,
20 Ms. Olson.

21 MS. OLSON: If I understand correctly, if we
22 approve then a multi-specialty surgery center, they do not
23 have to come back.

24 MR. CONSTANTINO: That's correct.

1 MR. URSO: That's unless they put a condition
2 on them.

3 MS. OLSON: I don't want to make a motion to
4 put that condition on them.

5 CHAIRMAN GALASSIE: Let me stop, because
6 Dr. Burden was suggesting another condition that I thought
7 was already in the rules. So, I think you're suggesting
8 you'd like a condition that, should they add additional
9 services other than what's in this application, they could
10 come back in front of this Board to do so.

11 MR. BURDEN: Yes.

12 CHAIRMAN GALASSIE: Is the applicant
13 generally in agreement with that?

14 MS. LEVITIN: Yes.

15 CHAIRMAN GALASSIE: You would agree then that
16 if you were to have any additional services beyond What's
17 in the application, you would have to come back through the
18 Board to do so?

19 MS. LEVITIN: Yes.

20 CHAIRMAN GALASSIE: Again, that would be part
21 of the friendly amendment to this motion. Are we
22 comfortable with moving forward?

23 I need a motion and a second.

24 MS. OLSON: So moved.

1 MR. GREIMAN: Second.

2 MR. ROATE: Motion made by Ms. Olson, seconded
3 by Justice Greiman.

4 Mr. Bradley?

5 MR. BRADLEY: Based on the impact on other
6 facilities, I vote no.

7 MR. ROATE: Dr. Burden?

8 MR. BURDEN: Based on some of the issues I
9 raised -- namely, the opinion that we have significant
10 numbers of already-functioning ASTC's which are not up to
11 the optimum -- I say no.

12 MR. ROATE: Senator Demuzio?

13 MS. DEMUZIO: Yes.

14 MR. ROATE: Justice Greiman?

15 MR. GREIMAN: Because the participants are
16 willing to make whatever changes the Board asks, I vote
17 yes.

18 MR. ROATE: Mr. Hayes?

19 MR. HAYES: In this case, I'm going to vote
20 no, because of the impact on other facilities, and, also,
21 I'm concerned about the financial feasibility and some of
22 the questions on the operation of this facility.

23 MR. ROATE: Ms. Olson?

24 MS. OLSON: I vote yes.

1 MR. ROATE: Mr. Sewell?

2 MR. PENN: I vote yes.

3 MR. ROATE: Chairman Galassie?

4 CHAIRMAN GALASSIE: Yes.

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

7 CHAIRMAN GALASSIE: Motion passes.
8 Congratulations. Thank you.

9 (Pause)

10 CHAIRMAN GALASSIE: We're running difficult
11 for time. I'm hoping we will at least get through our
12 applicants, and I will try to expedite Board business that
13 we have remaining. It looks like we will be here until
14 4:30.

15 We have three requests for a public comment on
16 Item 12-039, ManorCare Health Services.

17 (Pause)

18 CHAIRMAN GALASSIE: Mark Weldler, Mark
19 Silberman, and Joyce Surdick. Good afternoon, folks. If
20 you would introduce yourselves and spell your name, and
21 when you give us your two-minute comment, let us know if
22 you're opposing or supporting. Thank you.

23 MS. SURDICK: Joyce Surdick (spells name).
24 I'm the Administrator of Fair Oaks Healthcare Center in

1 Crystal Lake. I'm going to try to make this short. It's
2 the end of the day, so I'm sure you're all tired.

3 In my estimation, a Certificate of Need should
4 be granted for only one reason, and that is need. There is
5 no need in Crystal Lake for another nursing home.
6 Currently, the three nursing homes in Crystal Lake are all
7 below target utilization. I personally was quite insulted
8 by ManorCare's assertion in their application -- because
9 Fair Oaks is a 46-bed facility -- that our percentage of
10 utilization was skewed because we are so small. And
11 (unintelligible). In my facility, that transfers to staff
12 being cut hours and not being able to pay their bills. I
13 know this is true also for the other nursing homes in the
14 area, because of the number of applicants of CNA's that we
15 get, looking for more hours because their hours are cut at
16 their facility. And it also makes it much more difficult
17 for us as a facility to meet our bills and obligations.

18 Just two years ago, Fair Oaks had an occupancy
19 at 90 percent consistently. This has gone down, and now
20 we're running in the 70 and 80 percent. I'm obviously not
21 an expert in this, but the way I see it, in our area it is
22 because home health has become such a big focus. It's --
23 every other week, we get a new home health service that
24 comes looking for business. So, I think a lot of patients

1 are going home, and this has a lot to do with Obama Care.

2 The other error that the application addresses
3 is services.

4 MR. MORADO: Thirty seconds.

5 MS. SURDICK: Obviously, we're all skilled
6 facilities and we all do skilled services. The community
7 does not need another nursing home and will not benefit,
8 and I am opposed.

9 CHAIRMAN GALASSIE: Thank you.

10 MR. WELDLER: My name is Mark Weldler. I want
11 to thank the Board for the opportunity to speak in front of
12 the Board. I know it's late in the day, so I'll try to
13 make it quick.

14 I'm the owner of a facility in Crystal Lake
15 called the Springs at Crystal Lake. We're a 97-bed
16 facility, and currently we have 30 beds that are
17 unoccupied. We are a five-star rated facility with CMS.
18 We apply all the services that the applicant claim were not
19 in the -- provided in the area -- IV'S, wound care,
20 bariatric, all of those services, other than maybe
21 ventilator services that we don't provide in our facility.
22 And in the State Agency Report, the State Agency says that
23 there are 26 facilities within 45 minutes of this proposed
24 facility. Of this 26, one facility is not yet operational

1 and 20 at the remaining 25 facilities do not meet target
2 utilization. If you go down to 30 minutes, there are 70
3 facilities within 30 minutes. Of those, 14 facilities do
4 not achieve the target utilization, and the average
5 occupancy of the facilities within 30 minutes of the
6 proposed site is less than 80 percent. The applicant
7 stated that possibly a reason for this is because maybe
8 there's not enough quality services in these facilities
9 which is why their census numbers are not there. If you
10 look at the part of the State Agency Report -- I believe it
11 starts on page 15 -- the Table Four there shows within the
12 Service Area the facilities, and of those facilities that
13 have either a four or five-star rating with CMS -- and we
14 are one of them -- 13 of those facilities have that rating.
15 Of the 13, 11 do not have utilization -- did not meet the
16 target utilization.

17 At the last meeting of the Board, the Board
18 approved, in addition, a 40-bed addition, which is in our
19 immediate area --

20 MR. MORADO: Thirty seconds.

21 MR. WELDLER: -- to our facility. That adds
22 even more capacity.

23 I would just like to end and thank you for
24 your consideration and would like to say in our opinion,

1 this facility is not needed. It would have a severe,
2 adverse impact on our facility if this was approved.

3 Thank you so much for your time.

4 CHAIRMAN GALASSIE: Thank you.

5 MR. SILBERMAN: Good afternoon. Thank you for
6 the opportunity to appear. My name is Mark Silberman
7 (spells name). I represent both of the facilities here, as
8 well as Crystal Pines.

9 Simply put, I want to just crystallize the
10 following question for the Board, which I think will make
11 it much shorter, which is, since the last time this project
12 was considered, when 7 Board members voted not to support
13 this project, what has changed? And the only things that
14 have changed are, one, referral letters and, two,
15 additional information.

16 Now, with regards to the referral letters, the
17 applicant sat before this Board and said they did not
18 submit referral letters because it was not possible to get
19 them. That was challenged by the members of this Board
20 and, in fact, they did go out and obtain referral letters.
21 However, if the Board members look closely at those
22 referral letters, there's not a commitment to providing any
23 actual residents to this facility if it's approved. There
24 are generalizations that they would consider it, but each

1 of these referral letters explicitly states there is no
2 commitment to provide residents.

3 Secondly, if you consider, these are all
4 residents that would be served by the existing facilities.
5 So, if you approve this project based on these residents
6 moving now to a newly-approved facility, it's going to
7 create an even greater maldistribution, because the volume
8 and existing capacity in this community is overwhelming.
9 You also have to consider that not only is Fair Oaks and
10 Crystal Pines engaged in renovation projects to increase
11 their capacity -- all allowed within the Board's rules --
12 but, as Mr. Weldler pointed out, this Board just approved
13 an additional 40 beds to a facility which is within the
14 immediate area, less than a half hour from the proposed
15 site.

16 The additional issue is that there was
17 additional information provided. Now, this project was
18 deferred from the last meeting, based on the applicant's
19 acknowledgement that there was misinformation that was
20 provided to the Board; but since this Staff Report doesn't
21 reflect what the misinformation was, I feel it's important
22 to address it. There was a claim presented that this
23 project needed to be approved because of an unavailability
24 of Medicaid, and they identified facilities that they

1 claimed did not accept Medicaid.

2 MR. MORADO: Thirty seconds.

3 MR. SILBERMAN: Those facilities, in fact, do,
4 and we provided the information to this Board that shows
5 all of those facilities do provide Medicaid. They also
6 presented arguments regarding need that aren't based on the
7 methodology of this Board, beds per thousand, or what the
8 needs of the County are. Based on this Board's need
9 methodology, it's very clear: 14 out of the 17 closest
10 facilities do not meet this threshold for expansion of the
11 creation of a new facility; 11 of the 13 four and five star
12 facilities are below the threshold. There may be a future
13 need in this Health Service Area, but it's not this project
14 and not in this area.

15 Thank you, and we appreciate the Board's
16 consideration.

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

19 Representatives from ManorCare.

20 (Pause)

21 CHAIRMAN GALASSIE: Good afternoon, folks.
22 Late in the day. In you would, please introduce yourselves
23 and spell your names. Look forward to having you sworn in.

24 MS. FRIEDMAN: Hi. I'm Kara Friedman.

1 MS. EDWARDS: Good afternoon. Nancy Edwards
2 (spells name).

3 MR. GODLA: Larry Godla (spells name).

4 MR. REPPY: And Don Reppy.

5 (Oath given)

6 CHAIRMAN GALASSIE: Thank you.

7 Staff report.

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

9 The applicants propose to establish a 130-bed
10 skilled nursing care facility in Crystal Lake. The total
11 cost of the project is approximately \$17 million. The
12 project completion date is November 30th, 2015. This
13 project received an Intent to Deny at the July meeting and
14 was deferred from the October 30th-31st meeting because of
15 travel issues due to the Sandy Hurricane. Additional
16 information was provided on August 21st, 2012 and October
17 26th, 2012 to address the Intent to Deny.

18 Thank you, Mr. Chairman.

19 CHAIRMAN GALASSIE: Thank you, sir.

20 Comments for the Board?

21 MS. EDWARDS: Thank you for this afternoon.

22 On behalf of HCR ManorCare, I'm Nancy Edwards,
23 Vice-President of Operations for our Illinois facilities,
24 and just by way of quick introductions, Larry Godla, our

1 Vice-President of Development and Construction, Don Reppy,
2 our Director of Health Planning, and Kara Friedman, our
3 outside legal counsel. We appreciate the opportunity to
4 discuss our proposal again for Crystal Lake today, and
5 before I give some concluding comments, I've asked Kara to
6 speak first, followed by Larry.

7 MS. FRIEDMAN: Thank you.

8 ManorCare's written submissions have addressed
9 the Board's identified concerns and responded to material
10 comments made about this proposal during the comment
11 period. We believe due process requires that the focus of
12 this time be on the issues put in the written record, as
13 the public has had ample time to provide written input. We
14 appreciate you taking time to consider this project on its
15 merits and will try to be brief.

16 We believe that ManorCare is well able and
17 deserves the opportunity to address any site issues that
18 are of concern to individual Board members following the
19 presentations that you just heard. In taking into account
20 the opposition to this project, none of the comments to
21 date by other providers have suggested that this proposal
22 would limit access by putting those providers out of
23 business. Those competitors know it's not the job of this
24 Board to protect their market share. If this proposal is

1 approved, those competitors will be free to continue to
2 operate their nursing facilities.

3 As for the merits of this project, first,
4 unlike some of the nursing home projects this Board has
5 recently scrutinized, which had finance plans involving
6 borrowing money, this project will be 100 percent financed
7 with cash reserves. Thus, this proposal complies with
8 nearly all of the Board's criteria, including all of the
9 Part 1120, Financial Viability and Economic Feasibility
10 requirements.

11 In the larger Health Service Area, there is a
12 need for more than 1,200 nursing home beds, and there's a
13 need for 469 such beds in McHenry County, which is the most
14 of any of the three counties in this Health Service Area.
15 The project referred to before is not being established in
16 McHenry County. As we've documented, the proposed site for
17 this facility is located in an area of McHenry County where
18 there is the greatest population density and the greatest
19 demand for skilled care.

20 The proposal is endorsed by 68 letters of
21 community support and referral letters, and the proposal is
22 consistent with the 2010 McHenry County Healthy Community
23 Study, which identified a lack of long-term services in the
24 county as a deficit in the county healthcare delivery

1 system.

2 This proposal has as many positive findings as
3 any nursing home project this Board has reviewed and
4 approved in the last three years. ManorCare is committed
5 to serving Medicaid patients in this facility, as they do
6 in all of their Illinois facilities. We want to bring that
7 to your attention, because we understand the value this
8 Board places on caring for individuals regardless of their
9 ability to pay, and I suspect that if the Springs at
10 Crystal Lake admitted Medicaid patients -- which they
11 admitted previously they do not -- they might be filling
12 those 30 beds that they cited.

13 Only one issue prevents this project from
14 presenting a completely positive Staff Report, which is the
15 occupancy of existing area providers, and Larry Godla will
16 address that issue.

17 MR. GODLA: Thanks, Kara.

18 First, as highlighted in the Staff Report, I
19 wanted to emphasize that based on the supplemental
20 submission we put in, the Board Staff has determined that
21 our application has properly documented the demand for this
22 service. Since you last considered this project, it is now
23 positive in the Section 1125.54 requirements.

24 I do want to point out that we pursued the

1 development of a facility in McHenry County based on the
2 Board's need determination. After assessing the Board's
3 rejections, which take into account growing demand, we
4 examined the area on our own, and based on our own market
5 criteria, agreed there is an unmet near-future need for
6 additional SNF beds in this county. The reason the need
7 projections are made is to ensure the necessary services
8 are available in the future. We are confident that the CON
9 Board's determination that a need in excess of the 130 beds
10 that we propose to build exists in this Planning Area, and
11 that is correct.

12 The only open issue in our application is the
13 occupancy of the other providers. Our experience
14 demonstrates that 75 percent of the admissions to our
15 Chicago area nursing homes come from residents within a
16 20-minute drive time. We don't believe the facilities
17 farther than 20 minutes away from home are a meaningful
18 option, especially in a more rural area. Further, once you
19 travel beyond that distance, you are actually outside of
20 McHenry County and into other Planning Areas, specifically
21 Kane and Lake Counties, both of which also have significant
22 bed-need listed, with the following observations about the
23 four closest facilities in the immediate Crystal Lake
24 marketplace.

1 The first is Sheltering Oak. This is a 70-bed
2 facility, closed in July, and does not seem likely to
3 reopen. If it does reopen, it treats a discreet, special
4 needs, MI patient population that would not duplicate our
5 proposed services.

6 Second is Crystal Pines. According to its
7 most recent Medicaid Cost Report, Crystal Pines is a
8 170-bed operating facility and averaged 100 patients in
9 2011. If occupancy were based on their operating beds, it
10 would be 93 percent occupied. Considering either licensed
11 or operating beds, this facility is over or near the
12 occupancy target.

13 Third, the Springs at Crystal Lake lower
14 occupancy can likely be attributed to the fact it does not
15 admit Medicaid patients. As Kara mentioned, one of the
16 mandates of your governing statute is to provide access to
17 financially needy patients. Our proposal will help address
18 that.

19 Finally, Fair Oaks' lower occupancy can be
20 attributed to the fact it's a small 46-bed facility. Its
21 average occupancy was 39 last year, which with two more
22 patients would be at 90 percent target occupancy, and it
23 reported having a peak census of 46 patients in its last
24 reporting period.

1 We feel the providers speaking in opposition
2 to this application admit there is a need in the county and
3 they are opposing this project out of their own competitive
4 interests.

5 Thank you for your consideration, and Nancy
6 Edwards is going to provide a few closing remarks for us.

7 MS. EDWARDS: Thank you, Larry.

8 HCR ManorCare is an integral part of the
9 Illinois healthcare community and the state's economy. By
10 way of background, in Illinois we operate 28 skilled
11 nursing facilities, 8 assisted living, 2 home healthcare
12 offices, and 4 hospice operations. Our skilled nursing
13 centers serve 3,800 patients of day, and in providing this
14 care in Illinois, we employ 6,100 individuals across the
15 state. In 2002 (sic), based on our historical experience,
16 we expect to provide nearly 800,000 days of care to
17 Medicare and Medicaid patients, which represents about
18 three and a half percent of patient days across the state.
19 The company has a proven track record of providing quality
20 care, and we strive to be the provider of choice in each
21 area that we serve.

22 I'm proud to say that our average number of
23 deficiencies on standard State surveys is 2.7, which is
24 less than half the average of 5.7 across the rest of the

1 state. Our commitment to being a superior provider and to
2 consistently providing a high level of service is good for
3 the communities we serve, as we help set that bar for
4 quality and patient satisfaction. In the areas we serve,
5 we are considered an important partner to each local
6 community hospital and the physician community.

7 In addition to our nursing home Medical
8 Directors, we employ almost 100 consulting physicians in
9 the Greater Chicagoland area, representing numerous
10 specialties, including infectious disease, cardiology,
11 nephrology, podiatry and pulmonology. These specialists,
12 along with our nurse practitioners trained in gerontology,
13 help us manage the more complex medical needs of our
14 patients.

15 We continue to strengthen our strategic
16 partnerships with acute care providers, several of whom
17 have recognized ManorCare as a Preferred Partner for
18 Excellence in short-term, post-acute services. One of
19 these partnerships is with the Advocate Christ
20 organization, who, as you know, appeared earlier on the
21 agenda today, with our Oak Lawn East facility now part of
22 their PAN, post-acute network program. I'm proud to say
23 that of the three SNF's that are associated with the Christ
24 ACO project, that we are currently enjoying a higher level

1 of volume of patients so far, as compared to the other two
2 providers. These services reduce rehospitalization rates
3 and provide a more cost-effective alternative to prolonged
4 hospital stays and, in fact, ManorCare differentiates
5 itself from other providers in a number of ways. I'd like
6 to share a few.

7 Number one, our proprietary (unintelligible)
8 clinical medical practice models are employed to improve
9 outcomes and reduce rehospitalizations for congestive heart
10 failure, acute myocardial infarction, and pneumonia
11 diagnoses, the three diagnoses which, you probably know,
12 are currently targeted by CMS for monitoring
13 rehospitalizations nationwide. Additional disease-specific
14 programs include those for joint replacement, heart
15 disease, stroke, diabetes, and a number of other diagnoses.

16 Number two, all of our current Chicagoland
17 centers have implemented the Gold Plan for Success program,
18 a long name for a program for our new rehab admissions.
19 This consists of an interdisciplinary team meeting that
20 takes place with family and patient within the first day
21 after admission and is followed up with periodic
22 inner-disciplinary team meetings. The purpose of the
23 program is to determine the appropriate length of stay and
24 to ensure successful discharge to home without

1 rehospitalization.

2 Number three, ManorCare is the only post-acute
3 provider who collects and reports FIM data, also known as
4 Functional Independence Measures based -- to measure the
5 effectiveness of our rehab programs. Many of our outcomes
6 exceed those of acute care in-patient rehab facilities.

7 Number four, all therapists working in our
8 organization are employees of HCR ManorCare, which ensures
9 consistency of programming and that therapist-to-patient
10 relationship throughout the length of stay. In addition,
11 our therapy programs include a significant respiratory
12 component, which is somewhat unique in the SNF setting.

13 And the fifth area I wanted to share is that
14 HCR ManorCare is the only provider with its own independent
15 advisory committee on quality, to provide guidance to the
16 company's Board of Directors on ways to measure, maintain,
17 and improve quality of clinical programming.

18 Finally, I'd also like to mention that we've
19 made a significant commitment company-wide to technology --
20 which is so important in today's healthcare environment --
21 through state-of-the-art communication tools, including
22 physician access to electronic health records, nurse
23 practitioner electronic notepads, Point-Click-Care
24 electronic medical records system, and handheld devices for

1 documentation by therapists.

2 In summary, across the state we serve a
3 diverse mix of urban, rural, short-term, post-acute, and
4 traditional long-term care patients that meets the specific
5 needs of the communities we serve; and at Crystal Lake, we
6 believe that we are proposing a state-of-the-art facility
7 that fully addresses the needs of this community, and we
8 ask for your approval to move forward with this project.

9 At this time, we're prepared to take any
10 questions.

11 CHAIRMAN GALASSIE: Thank you.

12 I'm going to open up to questions, and I see
13 Member Sewell --

14 MR. SEWELL: I need a CON 101 question for
15 Mike.

16 In this State Agency Report, it almost looks
17 like we're using the phrase "skilled nursing facility" and
18 "long-term care" interchangeably.

19 MR. CONSTANTINO: That's correct.

20 MR. SEWELL: Okay. So we have Planning Area
21 need estimates based on skilled nursing facilities?

22 MR. CONSTANTINO: That's correct.

23 MR. SEWELL: And that's what was applied here?

24 MR. CONSTANTINO: Yes.

1 MR. SEWELL: I just wanted to make sure. I
2 thought I knew that.

3 I guess I want the applicant to just address
4 these -- I mean, the biggest problem here is the low
5 utilization of existing facilities in the area. That's
6 where it appears that the problem is. And so why should we
7 sort of make an exception to that?

8 MS. FRIEDMAN: Well, we started out by
9 identifying the issues with the facilities that are
10 nearest, because, in fact, we feel that that is more
11 correctly the Service Area that should be considered. We
12 did take note that one of the facilities isn't providing
13 access and such. As you get into the larger Service Area,
14 we soon moved into the rural part of McHenry County, which
15 is moving away from sort of the patient base stream that's
16 more typical. This part of Crystal Lake is in the
17 southeast corner of the Planning Area and, therefore, this
18 is a population that typically moves south to Kane County,
19 a little bit east to Lake County, and then south to Cook
20 County for work and their daily activities, to the extent
21 they leave Crystal Lake. So, the idea of going 20 minutes
22 towards Woodstock -- which is not exactly a rural
23 community, but it's not a community that you can go to
24 access healthcare services. Typically when you're in that

1 part of the state, it doesn't really seem like a good
2 health planning exercise, we don't think, and then after
3 you get to that point, you are then out of the county and
4 into other Planning Areas where there is a need, and
5 there's been growing utilization of those facilities
6 throughout those three Planning Areas.

7 And I do think that you understand that I
8 don't really see that there is a disconnect between the
9 fact that there is a need for beds in the Planning Area and
10 there's also some facilities that are under 90 percent
11 utilization, given that we're planning for future use.

12 CHAIRMAN GALASSIE: Additional questions?

13 MR. BURDEN: I have one question. Why do we
14 continue to see projected occupancy data going up to 2018?

15 CHAIRMAN GALASSIE: Are we asking that of
16 Staff?

17 MR. BURDEN: Probably.

18 MR. CONSTANTINO: Yes. They have to -- two
19 years after project completion. They have to project two
20 years after project completion.

21 MR. BURDEN: They're looking at November 20,
22 2015, and you're going out three years after that, right?
23 I see -- where was this figure -- 400-some-odd number of
24 beds projected up through 2018, 469. I just find that

1 unusual. How in the hell do we know? We can't tell
2 sometimes two years how we're going to be.

3 MR. CONSTANTINO: You're talking about the
4 bed-need methodology?

5 MR. BURDEN: Yes.

6 MR. CONSTANTINO: Oh, I'm sorry. I thought
7 you were talking about the applicant's utilization. That's
8 our inventory estimate of how many beds are going to be
9 needed in that Planning Area.

10 MR. BURDEN: By 2018?

11 MR. CONSTANTINO: Yes.

12 MR. BURDEN: Six years from now. I just
13 find -- that's the first time I've seen that lengthy of a
14 bed-need methodology projected out that far, and I guess
15 there's a reason for it that I'm missing.

16 MR. CARVALHO: We used to use five years, and
17 then the Legislature told us to use ten years. A
18 particular situation kind of led to a statute that extended
19 it to 10 years. The statute has now been revised to go
20 back to 5 years and we are in the process. But for the
21 last couple years we've been using 10 because of the
22 statutory change.

23 MR. GODLA: Can I make a comment, sir?

24 CHAIRMAN GALASSIE: Very brief, sir.

1 MR. GODLA: I would say part of the way we
2 look at planning need is that these are long-term projects.
3 From the time the State Staff puts out a need for beds to
4 the time we go through a Certificate of Need process, a
5 zoning process, and the actual construction of a facility,
6 we're three years down the road to open a facility, four
7 years down the road before (unintelligible). So, what
8 we're doing is future planning and tracking the future
9 needs, is where we are.

10 CHAIRMAN GALASSIE: Senator Demuzio?

11 MR. DEMUZIO: Yes. Just one quick question.
12 I'm not familiar with the Service Area, but I see where
13 there is one facility that's not even open in the Elgin
14 area, and that is located, I guess, within a 45-minute
15 radius. Could you -- could Staff or someone tell me what
16 the opening date -- or when that one facility is going to
17 open? It says Addison Rehab and Living Center in Elgin,
18 not available. I assume that's the one that is not open,
19 and back in your notes it says, "One facility not open."

20 MR. CONSTANTINO: That's correct, and I
21 couldn't tell you what date that's going to be, the
22 projected date that is going to be open. I apologize.

23 MR. DEMUZIO: And how far would that be from
24 the applicant's location here today?

1 MR. CONSTANTINO: It's over 40 minutes.

2 MR. DEMUZIO: Thank you.

3 CHAIRMAN GALASSIE: Any other questions by
4 Board members?

5 (Pause)

6 CHAIRMAN GALASSIE: Hearing none, may I have a
7 motion to approve Project 12-039, ManorCare Health
8 Services, authorizing the establishment of 130-bed
9 long-term care facility in Crystal Lake, Illinois?

10 MR. GREIMAN: So moved.

11 MS. OLSON: Second.

12 CHAIRMAN GALASSIE: Moved and seconded. Roll
13 call, please.

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

16 Mr. Bradley?

17 MR. BRADLEY: Based on our standard of
18 unnecessary duplication of services, I vote no.

19 MR. ROATE: Thank you.

20 Dr. Burden?

21 MR. BURDEN: I share that sentiment. I vote
22 no.

23 MR. ROATE: Senator Demuzio?

24 MS. DEMUZIO: Same opinion. I vote no.

1 MR. ROATE: Justice Greiman?

2 MR. GREIMAN: I vote yes.

3 MR. ROATE: Mr. Hayes?

4 MR. HAYES: I vote yes.

5 MR. ROATE: Ms. Olson?

6 MS. OLSON: I vote yes.

7 MR. ROATE: Mr. Sewell?

8 MR. PENN: I vote no.

9 MR. ROATE: Chairman Galassie?

10 CHAIRMAN GALASSIE: No for reasons stated.

11 MR. ROATE: Five votes in the negative, three
12 votes in the affirmative.

13 MR. URSO: You'll be receiving a denial
14 notification from the Board. You'll have an opportunity
15 for due process, if you so desire. Thank you.

16 CHAIRMAN GALASSIE: We still have additional
17 business, and I will adjourn us at 4:30, but I will also
18 ask the Board -- maybe 10 minutes of Board business that we
19 have. I'm going to have an Executive Session. It's going
20 to take longer to leave the room than to have the Executive
21 Session, and it will be very, very brief. I wanted to give
22 you a two-minute break, but we don't have the two minutes.

23 Our apologies. It's always difficult to be
24 last. Introduce yourselves.

1 MS. RANALLI: Thank you. My name is Clare
2 Ranalli from Holland & Knight. With me to my left is
3 Richard Alderson (spells name), and Lori Wright (spells
4 name) from Fresenius.

5 (Oath given)

6 MR. CONSTANTINO: The applicants are proposing
7 the discontinuation and establishment of a 20-station ESRD
8 facility located in O'Fallon. The estimated cost of the
9 project is approximately \$3.5 million. The projected
10 completion date is September 30th, 2014. The applicants
11 received an Intent to Deny at the October State Board
12 meeting. Additional information in response to the Intent
13 to Deny was received November 2012.

14 Thank you, Mr. Chairman.

15 CHAIRMAN GALASSIE: Thank you, sir.

16 MS. RANALLI: We had prepared statements, but
17 given the time frame, we're going to be as brief as
18 possible.

19 This project is to relocate an existing
20 20-station facility. There is a need for five stations in
21 the Service Area, but we are not adding stations as a part
22 of the relocation. When we were before you previously, we
23 met all criteria, save one, and that was that we be 80
24 percent to relocate. Your rules required if you want to

1 relocate, you be at 80 percent utilization. It's a good
2 rule, and I imagine it is there to address a facility that
3 wants to relocate that may be significantly under utilized
4 but is unwilling to give up stations when it relocates.

5 We are not significantly under utilized. We
6 were at 76 percent utilization, when we appeared before you
7 at the previous meeting. We were at 78 percent utilization
8 today as we speak, and Mr. Alderson informs me there are
9 two patients who have gone through the admission process,
10 which would put them exactly at 80 percent utilization --
11 although in the interest of fairness, they're not there
12 today.

13 We also were remiss in not telling you when we
14 were here before, there is one isolation station at that
15 facility, and, as you know, that naturally decreases
16 utilization a little bit because the isolation station
17 cannot accept all patients, only those with communicable
18 diseases. So, it's not as heavily utilized.

19 So, I believe we're at your criteria or almost
20 there, and we would very much appreciate the ability to
21 relocate this clinic. We've been there for 20 years. It's
22 woefully small, given the 93 patients that it currently
23 serves, and has a whole host of other issues associated
24 with it, and it would be very costly and disruptive to the

1 patients to renovate it.

2 MR. BRADLEY: Mr. Chairman, I move that we
3 approve this project.

4 MS. OLSON: Second.

5 CHAIRMAN GALASSIE: Moved and seconded. Roll
6 call.

7 MR. ROATE: Motion made by Mr. Bradley,
8 seconded by Ms. Olson.

9 Mr. Bradley?

10 MR. BRADLEY: Yes.

11 MR. ROATE: Dr. Burden?

12 MR. BURDEN: Yes. It is good to be last.

13 MR. ROATE: Senator Demuzio?

14 MS. DEMUZIO: Yes.

15 MR. ROATE: Justice Greiman?

16 MR. GREIMAN: Yes.

17 MR. ROATE: Mr. Hayes?

18 MR. HAYES: Yes.

19 MR. ROATE: Ms. Olson?

20 MS. OLSON: Yes.

21 MR. ROATE: Mr. Sewell?

22 MR. SEWELL: Yes.

23 MR. ROATE: Chairman Galassie?

24 CHAIRMAN GALASSIE: Yes.

1 MR. ROATE: Eight votes in the affirmative.

2 CHAIRMAN GALASSIE: Motion passes.

3 Congratulations.

4 (Pause)

5 CHAIRMAN GALASSIE: Ladies and gentlemen, we

6 are going -- I need a motion to go into Executive

7 Session --

8 MS. OLSON: So moved.

9 MR. SEWELL: Second.

10 CHAIRMAN GALASSIE: Pursuant to (2)(c)(11).

11

12 EXECUTIVE SESSION HELD

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1 CHAIRMAN GALASSIE: Let the record show we
2 are out of Executive Session. There is about six minutes
3 remaining. I have a -- I'm going to ask for a motion to
4 approve implementing a pilot program, effective the next
5 meeting, for a four-month cycle whereby we will be
6 establishing public participation in the first 30 minutes
7 of our meetings. People can request to give their oral
8 testimony with a two-minute level. Those unable will have
9 an opportunity to submit written testimony, if they so
10 choose. This is a pilot program that we will evaluate
11 approximately four months from now. It is an intent to
12 better try to manage our meetings, a recognition that there
13 is not an unlimited amount of time and energy by this
14 volunteer board, yet a continued desire to conduct business
15 in an open meeting and try to give people an opportunity to
16 voice their opinion, but also recognizing there are public
17 hearings that precede this meeting. Nothing is perfect.

18 The motion got a little lengthy. I apologize.

19 MS. OLSON: I'll second, though.

20 MR. CONSTANTINO: Is that four meetings or
21 four months, Dale?

22 CHAIRMAN GALASSIE: Four meetings.

23 MR. SEWELL: I'll second it.

24 CHAIRMAN GALASSIE: Moved and seconded. All

1 in favor?

2 ("Ayes" heard)

3 CHAIRMAN GALASSIE: Opposed?

4 (No response)

5 CHAIRMAN GALASSIE: Hearing none, thank you.

6 We are on Compliance Issues.

7 MR. URSO: We don't have any compliance issues
8 we're going to be conveying to the Board at this meeting.

9 CHAIRMAN GALASSIE: Moving on, Other

10 Business: None. Rule Development: None. Unfinished

11 Business: None. New Business: Capital Expenditure

12 Report.

13 MR. CONSTANTINO: Mr. Chairman, we need
14 approval to approve that.

15 CHAIRMAN GALASSIE: Motion to approve the
16 Capital Expenditure Report?

17 MS. OLSON: So moved.

18 MR. SEWELL: Second.

19 CHAIRMAN GALASSIE: Moved and second. All in
20 favor?

21 ("Ayes" heard)

22 CHAIRMAN GALASSIE: Opposed?

23 (No response)

24 CHAIRMAN GALASSIE: Hearing none, motion

1 passes.

2 Financial Reports. You have this information.

3 Proposed Revised Guidelines: We've discussed,

4 motioned and passed.

5 Can I have a motion to adjourn?

6 MR. GREIMAN: Yeah.

7 MS. OLSON: Second.

8

9 MEETING ADJOURNED

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11 END TIME: 4:29 p.m.

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CERTIFICATE OF REPORTER

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

KAREN K. KEIM

CRR, RPR, CSR-IL, CCR-MO

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