

1 S100184

2 ILLINOIS DEPARTMENT OF PUBLIC HEALTH
3 HEALTH FACILITIES AND SERVICES REVIEW BOARD
4 OPEN SESSION

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6
7 REPORT OF PROCEEDINGS

8 Marriott Hotel and Conference Center
9 201 Broadway Street
Normal, Illinois 61761

10 August 27, 2014
11 9:06 a.m. to 3:57 p.m.

12
13 BOARD MEMBERS PRESENT:

14 MS. KATHY OLSON, Chairperson;
15 MR. JOHN HAYES, Vice Chairman;
16 MR. PHILIP BRADLEY;
17 DR. JAMES J. BURDEN;
18 SENATOR DEANNA DEMUZIO;
19 JUSTICE ALAN GREIMAN;
20 MR. DAVID PENN; and
21 MR. RICHARD SEWELL.

22
23 Reported by: Melani e L. Humphrey-Sonntag,
24 CSR, RDR, CRR, CCP, FAPR
Notary Public, Kane County, Illinois

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EX OFFICIO MEMBERS PRESENT:

MR. MATT HAMMOUDEH, IDHS; and
MR. MIKE JONES, IDHFS.

ALSO PRESENT:

MR. FRANK URSO, General Counsel ;
MS. COURTNEY AVERY, Administrator;
MR. NELSON AGBODO, Health Systems Data Manager;
MS. CATHERINE CLARKE, Board Staff;
MR. BILL DART, IDPH Staff;
MS. SANGEETA MATHI, Board Intern; and
MR. GEORGE ROATE, IDPH Staff.

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REPORT OF PROCEEDINGS -- 08/27/2014

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1 CHAIRPERSON OLSON: I apologize for the
2 late start. I was not watching the time.

3 Just -- we're just going to start with a
4 little bit of logistics this morning. This is going
5 to be a very long meeting. We have 65 people signed
6 up for public participation.

7 You can't hear me?

8 This is going to be a very long meeting. We
9 have 65 people signed up for public participation. As
10 noted on the website, people for public participation
11 will be given one minute this morning instead of two.
12 We need to move the agenda along.

13 Secondly, we will be mixing the agenda up
14 just a little bit this morning in order to be
15 considerate of people's time. If your project has no
16 opposition and no findings, we will be moving you to
17 the beginning of the agenda. You will be called
18 before public participation.

19 If there's nobody that's speaking on
20 projects this morning that have no opposition and no
21 finding -- if you are not in the room, you will not
22 lose your opportunity for your project to be heard.
23 We will catch you later.

24 I'm sure people came a little bit later,

REPORT OF PROCEEDINGS -- 08/27/2014
ROLL CALL

6

1 thinking that maybe it was going to be a long public
2 participation so they're not here. You're not going
3 to give up your chance to speak.

4 But in the interest of trying to let some of
5 you go instead of having you sit here all day, we are
6 going to move those to the top of the agenda.

7 That has been asked of all Board members, if
8 they're okay with that, and they have all agreed that
9 that would be okay. So I hope -- we'll try this and
10 see if this works out well. Maybe we'll continue that
11 practice.

12 So I'd like to call the meeting to order.
13 May I have a roll call, please.

14 MR. AGBODO: Thank you, Madam Chair.
15 Mr. Bradley.

16 MEMBER BRADLEY: Here.

17 MR. AGBODO: Dr. Burden.

18 MEMBER BURDEN: Here.

19 MR. AGBODO: Senator Demuzio.

20 MEMBER DEMUZIO: Here.

21 MR. AGBODO: Justice Greiman.

22 MEMBER GREIMAN: Here.

23 MR. AGBODO: Mr. Galassi.

24 (No response.)

REPORT OF PROCEEDINGS -- 08/27/2014

7

1 MR. AGBODO: Absent.

2 Mr. Hayes.

3 VICE CHAIRMAN HAYES: Here.

4 MR. AGBODO: Mr. Penn.

5 MEMBER PENN: Here.

6 MR. AGBODO: Mr. Sewell.

7 MEMBER SEWELL: Here.

8 MR. AGBODO: Madam Chair Olson.

9 CHAIRPERSON OLSON: Here.

10 I've just been advised by legal counsel that
11 I should ask for a motion to change the order of the
12 agenda.

13 May I have a motion, please.

14 MEMBER DEMUZIO: Motion.

15 MEMBER SEWELL: Second.

16 CHAIRPERSON OLSON: All those in favor
17 signify by voice vote.

18 (Ayes heard.)

19 CHAIRPERSON OLSON: Opposed, nay.

20 (No response.)

21 CHAIRPERSON OLSON: The motion passes.

22 So the first order of business will be --
23 now my agenda's all mixed up -- exemption
24 requests . . . oh, permit renewal requests -- no . . .

EXEMPTION REQUESTS -- 08/27/2014

8

1 I'm sorry.

2 Exemption requests, Saint Clare's Hospital,
3 for a change of ownership. Is Saint Clare in the
4 room?

5 Are they out there?

6 MS. RANALLI: They're outside.

7 CHAIRPERSON OLSON: Okay. Bring them
8 in. I'll go to the next one.

9 The next one is OSF/Saint Anthony's Health
10 Center for a change of ownership.

11 Is OSF in the room?

12 (No response.)

13 CHAIRPERSON OLSON: Oh, this is working
14 well.

15 MR. ROATE: That's the same group,
16 ma'am.

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**EXEMPTION REQUESTS -- 08/27/2014
PHYSICIANS' SURGICAL CENTER**

1 CHAIRPERSON OLSON: Oh, let's move on to
2 Physicians' Surgical Center for a change of ownership.

3 Is Physicians' Surgical Group in the room?

4 Thank you. I know I threw a curve ball here
5 but . . .

6 This is Project E-011-14, Physicians'
7 Surgical Center.

8 May I have a motion to approve Exemption
9 E-011-14, Physicians' Surgical Center.

10 VICE CHAIRMAN HAYES: So moved.

11 CHAIRPERSON OLSON: May I have a second.

12 MEMBER BRADLEY: Second.

13 CHAIRPERSON OLSON: Would the Applicant
14 have any comments to make, or can we open this to a
15 Board vote?

16 MR. OURTH: We're happy to proceed with
17 your questions.

18 CHAIRPERSON OLSON: Oh, I'm sorry. You
19 need to be sworn in.

20 The COURT REPORTER: Raise your right
21 hands, please.

22 (Three witnesses duly sworn.)

23 THE COURT REPORTER: And please state
24 each of your names and print your name on the sheet.

**EXEMPTION REQUESTS -- 08/27/2014
PHYSICIANS' SURGICAL CENTER**

1 MR. OURTH: Joe Ourth, O-u-r-t-h.

2 MS. GEOGHEGAN: Di ana Geoghegan,
3 G-e-o-g-h-e-g-a-n.

4 MR. BADHAM: Walter Badham, B-a-d-h-a-m.

5 THE COURT REPORTER: Thank you.

6 CHAIRPERSON OLSON: George, may I have
7 the State Board staff report.

8 MR. ROATE: Thank you, Madam Chair.

9 The Applicant is proposing to purchase
10 100 percent of Physicians' Surgical Center, a
11 multi special ty ambulatory surgical treatment center,
12 in Belleville, Illinois.

13 The approximate fair market value of the
14 transaction is \$2.2 million, and the anticipated
15 completion date is upon State Board approval.

16 There are no letters of opposition received
17 by State Board staff and no request for a public
18 hearing.

19 The Board staff wishes to note that the
20 Applicant -- the facility will be filing a declaratory
21 ruling to have data changed on its 2012 ASTC profile.
22 This data involves the Medicare and Medicaid net
23 revenue by payer source, which the numbers were simply
24 transposed.

**EXEMPTION REQUESTS -- 08/27/2014
PHYSICIANS' SURGICAL CENTER**

1 Thank you, Madam Chair.

2 CHAIRPERSON OLSON: Thank you, George.
3 Are there questions or comments from Board
4 members?

5 (No response.)

6 CHAIRPERSON OLSON: Seeing none, I will
7 call for a vote.

8 Roll call, please.

9 MR. AGBODO: Thank you, Madam Chair.
10 Mr. Bradley.

11 MEMBER BRADLEY: Yes.

12 MR. AGBODO: Dr. Burden.

13 MEMBER BURDEN: Yes.

14 MR. AGBODO: Senator Demuzio.

15 MEMBER DEMUZIO: Yes.

16 MR. AGBODO: Justice Greiman.

17 MEMBER GREIMAN: Yes.

18 MR. AGBODO: Mr. Hayes.

19 VICE CHAIRMAN HAYES: Yes.

20 MR. AGBODO: Mr. Penn.

21 MEMBER PENN: Yes.

22 MR. AGBODO: Mr. Sewell.

23 MEMBER SEWELL: Yes.

24 MR. AGBODO: Madam Chair Olson.

**EXEMPTION REQUESTS -- 08/27/2014
PHYSICIANS' SURGICAL CENTER**

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CHAIRPERSON OLSON: Yes.

MR. AGBODO: 8 in the affirmative.

CHAIRPERSON OLSON: The motion passes.

Thank you.

MR. OURTH: Thank you.

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**EXEMPTION REQUESTS -- 08/27/2014
OSF/SAINT CLARE'S HOSPITAL**

1 CHAIRPERSON OLSON: The next one is
2 OSF/Saint Anthony's Health Center. Come to the table.

3 There are two projects, OSF/Saint Clare's
4 Hospital and OSF/Saint Anthony's Health Center.

5 Thank you.

6 May I have a motion to approve
7 Project E-009-14, OSF/Saint Clare Hospital, for a
8 change of ownership.

9 MEMBER BRADLEY: So moved.

10 MEMBER SEWELL: Second.

11 VICE CHAIRMAN HAYES: Second.

12 CHAIRPERSON OLSON: The State Board
13 staff report, please -- oh, let's swear the gentlemen
14 in, please.

15 THE COURT REPORTER: Would you raise
16 your right hands, please.

17 (Four witnesses duly sworn.)

18 THE COURT REPORTER: Thank you. And
19 please state your names and print your name on a
20 sheet.

21 MR. HOHULIN: Mark Hohulin,
22 H-o-h-u-l-i-n.

23 MR. NELSON: Michael Nelson,
24 N-e-l-s-o-n.

**EXEMPTION REQUESTS -- 08/27/2014
OSF/SAINT CLARE'S HOSPITAL**

1 MR. HENDERSON: Michael Henderson,
2 H-e-n-d-e-r-s-o-n.

3 MR. PARKHURST: Ed Parkhurst,
4 P-a-r-k-h-u-r-s-t.

5 CHAIRPERSON OLSON: Thank you.
6 May I have the State Board staff report.

7 MR. ROATE: Thank you, Madam Chair.

8 The Applicants are Saint Anthony's Health
9 System, doing business as Saint Clare's Hospital in
10 Alton. The Applicant will merge into OSF Healthcare
11 System with OSF Healthcare System resulting as the
12 surviving corporate entity.

13 The Applicant, Saint Clare Hospital, is a
14 58 long-term care rehabilitation -- 58-bed long-term
15 care rehabilitation hospital located in Alton,
16 Illinois. The facility currently contains
17 30 long-term care beds and 28 rehabilitation beds.
18 The 2012 hospital profile notes there's 48.2 percent
19 overall occupancy.

20 Thank you, Madam Chair.

21 CHAIRPERSON OLSON: Thank you, George.

22 Before we proceed, Frank, do you want to
23 just mention our standing condition on change of
24 ownerships so the Applicants will have that?

**EXEMPTION REQUESTS -- 08/27/2014
OSF/SAINT CLARE'S HOSPITAL**

15

1 MR. URSO: Yeah.

2 So you know the two-year commitment for not
3 changing any of your policies in terms of charity
4 policies and -- and things along that line?

5 I just wanted to make sure I had the right
6 verbiage.

7 You're familiar with those commitments and
8 you abide by those; correct?

9 MR. HOHULIN: (Mr. Hohulin nodded his
10 head up and down.)

11 CHAIRPERSON OLSON: Thank you.

12 MR. URSO: Thank you.

13 CHAIRPERSON OLSON: Could you please
14 just say yes for the record?

15 MR. HOHULIN: Yes.

16 CHAIRPERSON OLSON: Thank you.

17 Are there questions from Board members on
18 this project?

19 (No response.)

20 CHAIRPERSON OLSON: Seeing none, I would
21 ask for a roll call vote.

22 MR. AGBODO: Thank you, Madam Chair.

23 The motion was made by Mr. Bradley; seconded
24 by Mr. Hayes.

**EXEMPTION REQUESTS -- 08/27/2014
OSF/SAINT CLARE'S HOSPITAL**

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Mr. Bradley.
MEMBER BRADLEY: Yes.
MR. AGBODO: Dr. Burden.
MEMBER BURDEN: Yes.
MR. AGBODO: Senator Demuzio.
MEMBER DEMUZIO: Yes.
MR. AGBODO: Justice Greiman.
MEMBER GREIMAN: Yes.
MR. AGBODO: Mr. Hayes.
VICE CHAIRMAN HAYES: Yes.
MR. AGBODO: Mr. Penn.
MEMBER PENN: Yes.
MR. AGBODO: Mr. Sewell.
MEMBER SEWELL: Yes.
MR. AGBODO: Madam Chair Olson.
CHAIRPERSON OLSON: Yes.
MR. AGBODO: 8 in the affirmative.
CHAIRPERSON OLSON: The motion passes.
MR. NELSON: Thank you.
MR. HOHULIN: Thank you.

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**EXEMPTION REQUESTS -- 08/27/2014
OSF/SAINT ANTHONY'S HEALTH CENTER**

17

1 CHAIRPERSON OLSON: And I believe you
2 will be remaining at the table -- or is this different
3 characters for the next -- or Applicants -- for the
4 next motion?

5 Saint Clare Hospital, Alton.

6 MR. HOHULIN: Correct, same.

7 CHAIRPERSON OLSON: And can I have the
8 State Board staff report?

9 MR. ROATE: Thank you, Madam Chair.
10 We're taking Exemption No. E-010-14;
11 correct?

12 CHAIRPERSON OLSON: Right. Let me get
13 the motion here.

14 I apologize. I threw myself a curve, too.

15 May I have a motion to approve Exemption
16 Project E-010-14, Saint Anthony's Health Center.

17 May I have a motion.

18 MEMBER SEWELL: So moved.

19 MEMBER BRADLEY: Second.

20 MEMBER GREIMAN: Second.

21 CHAIRPERSON OLSON: Okay. Thank you.

22 Now, George, State Board staff report.

23 MR. ROATE: Thank you, Madam Chair.

24 The Applicant is St. Anthony's Health

EXEMPTION REQUESTS -- 08/27/2014
OSF/SAINT ANTHONY'S HEALTH CENTER

18

1 System, doing business as Saint Anthony's Health
2 Center in Alton. The Applicant will merge into
3 OSF Healthcare System with OSF Healthcare System
4 resulting as the surviving corporate entity.

5 Saint Anthony's Health Center is a 145-bed
6 acute care hospital located in Alton, Illinois,
7 containing 101 medical/surgical beds, 19 intensive
8 care beds, 20 obstetric/gynecology beds, and
9 5 pediatric beds. The overall occupancy for calendar
10 year 2012, per the profile, was 29.5 percent overall.

11 Thank you, Madam Chair.

12 CHAIRPERSON OLSON: Just for clarity,
13 this is actually one transaction with two separate
14 requests?

15 MR. HOHULIN: Correct.

16 CHAIRPERSON OLSON: Are there other
17 questions or comments from the Board members?

18 (No response.)

19 CHAIRPERSON OLSON: Seeing none, I would
20 ask for a roll call vote, please.

21 MR. AGBODO: Thank you, Madam Chair.

22 Motion made by Mr. Sewell; seconded by
23 Mr. Penn.

24 Mr. Bradley.

**EXEMPTION REQUESTS -- 08/27/2014
OSF/SAINT ANTHONY'S HEALTH CENTER**

19

1 MEMBER BRADLEY: Yes.
2 MR. AGBODO: Dr. Burden.
3 MEMBER BURDEN: Yes.
4 MR. AGBODO: Senator Demuzio.
5 MEMBER DEMUZIO: Yes.
6 MR. AGBODO: Justice Greiman.
7 MEMBER GREIMAN: Yes.
8 MR. AGBODO: Mr. Hayes.
9 VICE CHAIRMAN HAYES: Yes.
10 MR. AGBODO: Mr. Penn.
11 MEMBER PENN: Yes.
12 MR. AGBODO: Mr. Sewell.
13 MEMBER SEWELL: Yes.
14 MR. AGBODO: Madam Chair Olson.
15 CHAIRPERSON OLSON: Yes.
16 MR. AGBODO: 8 votes in the affirmative.
17 CHAIRPERSON OLSON: The motion passes.
18 Thank you, gentlemen.
19 MR. HOHULIN: Thank you.
20 MR. NELSON: Thank you.
21 MR. URSO: Before you leave the table,
22 do you affirm, for this particular change of
23 ownership, that you're going to commit to the
24 two years of no change in the charity care policy?

**EXEMPTION REQUESTS -- 08/27/2014
OSF/SAINT ANTHONY'S HEALTH CENTER**

1 From this date forward for two years; correct?

2 MR. HOHULIN: Yes.

3 MR. URSO: Thank you.

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EXEMPTION REQUESTS -- 08/27/2014
MARYVILLE BEHAVIORAL HEALTH HOSPITAL

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1 CHAIRPERSON OLSON: Next, we have
2 Project E-16-14, Maryville Behavioral Health Hospital,
3 for a change of ownership.

4 Is Maryville in the room?

5 (Ex Officio Member Hammoudeh
6 joined the proceedings.)

7 CHAIRPERSON OLSON: Okay. The
8 Applicants will please be sworn in.

9 The COURT REPORTER: Would you raise
10 your right hands, please.

11 (Eight witnesses duly sworn.)

12 THE COURT REPORTER: Thank you. And
13 please state your names in order and each of you
14 sign -- or print on the sheet, please.

15 SISTER RYAN: Sister Catherine Ryan.

16 DR. KRESCH: Richard Kresch.

17 MR. NOVAK: Joe Novak.

18 CHAIRPERSON OLSON: May I have a motion
19 to approve Exemption E-016-14, Maryville Behavioral
20 Health Hospital, to approve a change of ownership for
21 its AMI hospital in Maryville.

22 MEMBER PENN: So moved.

23 MEMBER BRADLEY: Second.

24 CHAIRPERSON OLSON: State Board staff

EXEMPTION REQUESTS -- 08/27/2014
MARYVILLE BEHAVIORAL HEALTH HOSPITAL

22

1 report, please.

2 MR. ROATE: Thank you, Madam Chair.

3 The Applicants are 2014 Health, LLC, doing
4 business as Chicago Behavioral Health Hospital,
5 US HealthVest, LLC, and Maryville Behavioral Health
6 Hospital.

7 The Applicants propose a change of ownership
8 of Maryville Behavioral Health Hospital in
9 Des Plaines, Illinois, and this will be accomplished
10 through an asset purchase agreement. The anticipated
11 purchase price of the hospital is \$23 million.

12 Maryville Behavioral Health is a 125-bed
13 inpatient psychiatric hospital with programs designed
14 for children, adolescents, and young adults ages 3
15 through 20.

16 Letters of support were received from the
17 following individuals -- or from -- letters of support
18 were received in regard to the project to include a
19 letter from Cardinal George, Archbishop of Chicago,
20 and a letter from the Attorney General's office
21 stating there are no discrepancies with this
22 transaction.

23 Thank you, Madam Chair.

24 CHAIRPERSON OLSON: Questions or

EXEMPTION REQUESTS -- 08/27/2014
MARYVILLE BEHAVIORAL HEALTH HOSPITAL

23

1 comments from Board members?

2 MEMBER GREIMAN: Actually, did you say
3 that the Attorney General -- the issue with the
4 Attorney General as far as a not-for-profit is done?
5 That's taken care of?

6 MR. ROATE: Yes, sir.

7 MEMBER GREIMAN: Okay. Thank you.

8 CHAIRPERSON OLSON: Other questions or
9 comments?

10 Doctor.

11 MEMBER BURDEN: Thank you, Madam Chair.

12 Briefly, I understand that there's three
13 clamors for change at this institution, which has a
14 lengthy history in our community.

15 I've been around for at least 60 years,
16 involved indirectly, known many people that are
17 involved with the institution, so I'm concerned about
18 this aspect of the change: You're switching from a
19 nonprofit organization to a profit organization, and
20 I note, at the end of two years, the charity care
21 program well might be changed.

22 I would like to have some clarity on that
23 since that's in the prospectus I read. Is that a
24 possibility?

EXEMPTION REQUESTS -- 08/27/2014
MARYVILLE BEHAVIORAL HEALTH HOSPITAL

24

1 Is there some guarantee that the institution
2 remains serving the community needs as it has for so
3 many, many years?

4 And that's a concern of mine.

5 DR. KRESCH: I can assure you that, for
6 two reasons, the charity care policy will not change.

7 One is that the policy, as put forth in the
8 application, is the standard charity care policy that
9 we have used for many, many years in other facilities.

10 And, secondly, as a Medicaid provider, the
11 facility is subject to EMTALA regulations and, in
12 order to remain in compliance with the law, all
13 patients will be treated regardless of ability to pay.

14 MEMBER BURDEN: Thank you.

15 I suppose it's clear, in terms of the
16 history and what's occurred at this institution over
17 many years, that the quality of the personnel involved
18 will remain at a level to secure the safety of all
19 residents of this institution as we go forward,
20 recognizing that -- as many changes are currently in
21 vogue and we see them here -- we're changing to a
22 for-profit operation.

23 And having been involved in many for-profit
24 operations myself, I realize that sometimes for-profit

EXEMPTION REQUESTS -- 08/27/2014
MARYVILLE BEHAVIORAL HEALTH HOSPITAL

25

1 occurs because we cut back on expenses in some way.
2 This institution really survives with charity care,
3 donations, community support, and has always
4 survived -- maybe not as well as they would have liked
5 but has survived -- with the help of many people, some
6 of whom I know personally, so I'm concerned a little
7 bit about the for-profit stance that will occur at
8 this institution.

9 That's it. Thank you.

10 CHAIRPERSON OLSON: Other questions or
11 comments from Board members?

12 VICE CHAIRMAN HAYES: Madam Chair.

13 CHAIRPERSON OLSON: Yes, John.

14 VICE CHAIRMAN HAYES: I'm looking at
15 your -- I just want to be able to understand that --
16 the -- your income statement at Maryville Behavioral
17 Health Hospital, the income statement there.

18 And for 2011 and 2012, you actually had a
19 net surplus. And then in 2013 -- and I see where, you
20 know, you have a loss of -- a net deficit of
21 4.1 million, 4.2 million there.

22 I noted -- I noticed that your -- obviously,
23 your average daily census declined significantly, but
24 I noticed that expenses actually increased

EXEMPTION REQUESTS -- 08/27/2014
MARYVILLE BEHAVIORAL HEALTH HOSPITAL

26

1 significantly, so I was wondering if you had any
2 comment on that.

3 SISTER RYAN: Mr. Hayes, I would say
4 that our chief financial officer is here, Norm Joyce,
5 and he can add to this.

6 I would simply make the point that one of
7 the reasons for the expenses was the significant
8 investment we are making in staff-to-patient ratios.
9 Given the high acuity of the children we were serving
10 and we were privileged to serve, we needed to bring on
11 more staff to maintain a staff-patient ratio in
12 accordance with the guidelines of the American Academy
13 of Psychiatry, and we did not maintain the kind of
14 census that would allow us to spread some of that
15 cost.

16 But we had some additional expenses, as
17 well, and if you'd like more detail, I would be happy
18 to call up our chief financial officer, if that's
19 agreed.

20 CHAIRPERSON OLSON: That's fine, but we
21 need to swear you in, sir. State your name and raise
22 your right hand and be sworn in.

23 MR. JOYCE: Yes. Norm Joyce, chief
24 financial officer, Maryville.

EXEMPTION REQUESTS -- 08/27/2014
MARYVILLE BEHAVIORAL HEALTH HOSPITAL

27

1 Sister Catherine did --

2 CHAIRPERSON OLSON: We need to swear
3 you in.

4 THE COURT REPORTER: He was sworn
5 previously -- were you sworn previously against the
6 wall?

7 CHAIRPERSON OLSON: No. He just
8 stepped up.

9 THE COURT REPORTER: Raise your right
10 hand, please. Do you hereby swear --

11 MR. JOYCE: Yes, I was sworn in.

12 CHAIRPERSON OLSON: Oh, I'm sorry.
13 I didn't see that.

14 MR. URSO: Do you swear that you've been
15 sworn in?

16 (Laughter.)

17 MR. JOYCE: Sister Catherine did speak
18 directly to one of the reasons why our expenses did go
19 up, and one of it was we did need increased staffing.

20 MEMBER GREIMAN: Can you use the
21 microphone?

22 MR. JOYCE: Acuity was considerably
23 higher --

24 MR. URSO: Could you speak into the

EXEMPTION REQUESTS -- 08/27/2014
MARYVILLE BEHAVIORAL HEALTH HOSPITAL

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1 microphone, please? We can't hear you.

2 CHAIRPERSON OLSON: Pull it closer
3 to you.

4 MR. JOYCE: Is that better?

5 MR. URSO: Is it on?

6 There should be a button on it.

7 MR. JOYCE: Okay. Is that better now?

8 MR. URSO: No.

9 MR. JOYCE: How about this?

10 No?

11 No?

12 MS. AVERY: Okay.

13 MR. JOYCE: I'll try to speak louder.

14 CHAIRPERSON OLSON: Please.

15 MR. JOYCE: Yes. The acuity did

16 increase and one of the reasons that we had to

17 increase expenses was just for that reason.

18 We did have to enrich the ratios of staff

19 because of the situation that we had. And more than

20 anything, I think we wanted to make sure that we had

21 the safety of the patients and the staff in mind --

22 that was most critical -- so at that time we made that

23 choice.

24 However, unfortunately, even though we had

EXEMPTION REQUESTS -- 08/27/2014
MARYVILLE BEHAVIORAL HEALTH HOSPITAL

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1 budgeted higher census, that census did not
2 materialize, and so we had kind of a situation where
3 the expenses were there but the census didn't create
4 the revenue that we had hoped, so we had that reversal
5 of our financial results for that period.

6 It was a difficult situation.

7 VICE CHAIRMAN HAYES: Could you have cut
8 expenses? You know, cut back on this staffing level,
9 as others?

10 Because, basically, either -- you went from
11 12.3 to 14.4 and then all the way up to 16.5.

12 MR. JOYCE: Correct.

13 I think, too, that -- it would have been to
14 the detriment of the program, and it would have also
15 meant that we would have anticipated much lower
16 census, which wasn't what we anticipated at that time.

17 There were a lot of dynamics happening at
18 that time, so, unfortunately, we needed to keep on
19 course with regard to the amount of resources we put
20 into the hospital.

21 VICE CHAIRMAN HAYES: Okay. Now,
22 this -- you had an evaluation done -- and I think it's
23 reasonable -- of \$23 million. Is that correct?

24 MR. JOYCE: Correct, the purchase price.

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MARYVILLE BEHAVIORAL HEALTH HOSPITAL

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1 VICE CHAIRMAN HAYES: The purchase price
2 of 23 million.

3 And what about the -- I was just wondering,
4 when you bought -- Maryville bought this hospital --
5 what was it? -- about 15 years ago?

6 MR. JOYCE: It was 1999.

7 VICE CHAIRMAN HAYES: Okay. And what
8 was the price there of that?

9 MR. JOYCE: The price was approximately
10 \$10 million, including the land.

11 THE COURT REPORTER: I'm sorry.
12 Including what?

13 MR. JOYCE: \$10 million including the
14 land.

15 THE COURT REPORTER: Thank you.

16 VICE CHAIRMAN HAYES: Okay. So you
17 managed to -- so, basically, you did have a --
18 what? -- a donation -- a foundation set up to be able
19 to buy the hospital?

20 MR. JOYCE: Can I ask Sister Cathy to
21 speak to that?

22 SISTER RYAN: Sure.

23 MR. JOYCE: She was, at that time,
24 dealing with it.

EXEMPTION REQUESTS -- 08/27/2014
MARYVILLE BEHAVIORAL HEALTH HOSPITAL

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1 CHAIRPERSON OLSON: We're working on the
2 microphones.

3 Go ahead and try it.

4 SISTER RYAN: I'll try it.

5 CHAIRPERSON OLSON: Yeah.

6 SISTER RYAN: The light is on but
7 I don't think there's any --

8 MR. URSO: It seems like it's working.

9 CHAIRPERSON OLSON: Hold it very close
10 to your mouth.

11 SISTER RYAN: Like this?

12 CHAIRPERSON OLSON: Yes. There we go.

13 DR. KRESCH: Sounds good.

14 SISTER RYAN: Prior to my time at
15 Maryville but in 1999, there were donations from a
16 family foundation which made it possible for Maryville
17 to purchase the hospital.

18 There were also some circumstances of the
19 for-profit owner at that time, who was in a hurry to
20 sell the hospital, as I understand it, because of some
21 disagreements he had with the Federal government on
22 Medicare payments.

23 So . . . that precedes me but this is what
24 I understand to be the background. So the hospital

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MARYVILLE BEHAVIORAL HEALTH HOSPITAL

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1 may have been purchased for a little less than it
2 would have sold for had it been sold under other
3 circumstances.

4 VICE CHAIRMAN HAYES: Because,
5 basically, the foundation is -- you know, they
6 basically feel that -- you feel that the foundation --
7 the requirements of that gift are being met by this
8 sale to this hospital?

9 SISTER RYAN: Yes. Yes.

10 I would also say that we have -- Maryville,
11 since the purchase, has invested more than \$16 million
12 in the hospital since that purchase. So we've -- we
13 really tried to provide good service to the children,
14 improve the physical environment, the staffing levels
15 that we talked about.

16 We have been privileged to serve very dear
17 children who have highly acute mental health
18 conditions, and there were times -- a number of
19 patients we served -- where we have to have at least
20 1 staff person only for them, not working with anyone
21 else, in addition to maintaining no less than 1 mental
22 health counselor for every 4 and 1 nurse for at least
23 every 12 patients and sometimes more.

24 So we have really tried to invest in the

EXEMPTION REQUESTS -- 08/27/2014
MARYVILLE BEHAVIORAL HEALTH HOSPITAL

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1 hospital. And we believe in the ministry, but we have
2 come to learn that the way to make this a successful
3 venture -- that is to say to pay the bills -- not to
4 get rich but to pay the bills -- that it was necessary
5 to be able to serve adults as well as children.

6 And we believe in that ministry but it isn't
7 ours. We're dedicated to children and their families.
8 And so we were grateful to find a partner who would
9 expand the office -- offerings of the hospital to
10 adults as well as children, but we don't choose to
11 do that.

12 VICE CHAIRMAN HAYES: No. Thank you
13 very much. I understand that -- the charitable nature
14 of the -- your mission there, and I certainly
15 appreciate that.

16 One final question on -- this is being
17 acquired by US HealthVest, LLC, and through an
18 Illinois corporation. And I understand that -- does
19 US HealthVest -- that company, does that actually have
20 any other hospitals at this time that you're running?

21 DR. KRESCH: Currently US HealthVest
22 does not operate any hospitals but has two hospitals
23 that are -- have been granted certificates of need in
24 other states and they're currently under construction

EXEMPTION REQUESTS -- 08/27/2014
MARYVILLE BEHAVIORAL HEALTH HOSPITAL

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1 number of beds that are present today in the inventory
2 for the Board will remain the same for 12 months.

3 DR. KRESCH: Yes.

4 MR. URSO: Thank you.

5 CHAIRPERSON OLSON: Thank you.

6 Seeing no further comments or questions,
7 I would ask for a roll call vote, please.

8 MR. AGBODO: Thank you, Madam Chair.

9 The motion was made by Mr. Penn; seconded by
10 Mr. Bradley.

11 Mr. Bradley.

12 MEMBER BRADLEY: Yes.

13 MR. AGBODO: Dr. Burden.

14 MEMBER BURDEN: Yes.

15 MR. AGBODO: Senator Demuzio.

16 MEMBER DEMUZIO: Yes.

17 MR. AGBODO: Justice Greiman.

18 MEMBER GREIMAN: Yes.

19 MR. AGBODO: Mr. Hayes.

20 VICE CHAIRMAN HAYES: Yes.

21 MR. AGBODO: Mr. Penn.

22 MEMBER PENN: Yes.

23 MR. AGBODO: Mr. Sewell.

24 MEMBER SEWELL: Yes.

**EXEMPTION REQUESTS -- 08/27/2014
MARYVILLE BEHAVIORAL HEALTH HOSPITAL**

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1 MR. AGBODO: Madam Chair Olson.

2 CHAIRPERSON OLSON: Yes.

3 MR. AGBODO: 8 votes in the affirmative.

4 CHAIRPERSON OLSON: We wish you luck.

5 Your motion passes. It's a worthy cause.

6 SISTER RYAN: Can I say something?

7 CHAIRPERSON OLSON: Yes.

8 SISTER RYAN: I just wanted to thank the
9 staff of the Board for their guidance and support
10 during this process, helping us to try to do the
11 things correctly.

12 Thank you.

13 CHAIRPERSON OLSON: I know it's been a
14 lengthy process for you. Glad you could get some
15 closure behind it.

16 Thank you.

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**SUBSEQUENT TO INITIAL REVIEW -- 08/27/2014
DAVITA STONY CREEK DIALYSIS**

37

1 CHAIRPERSON OLSON: Okay. Next, we will
2 call DaVi ta Stony Creek Dialysis, Oak Lawn. Are they
3 in the room?

4 (No response.)

5 CHAIRPERSON OLSON: Oh, great.
6 And this . . . this is Project H-05 . . .

7 MEMBER GREIMAN: I'm sorry. What's the
8 number?

9 CHAIRPERSON OLSON: H-05.

10 MEMBER GREIMAN: H?

11 CHAIRPERSON OLSON: H, as in "Henry."

12 MEMBER GREIMAN: H, yeah.

13 CHAIRPERSON OLSON: Okay. Could you
14 please be sworn in with the court reporter.

15 (Two witnesses duly sworn.)

16 THE COURT REPORTER: Thank you. And
17 please state your names and print your names on the
18 sheet.

19 MR. SHEETS: Chuck Sheets from
20 Polsinelli on behalf of DaVi ta Health Care Partners,
21 and I have with me Anne Cooper from the same office.

22 THE COURT REPORTER: Thank you.

23 CHAIRPERSON OLSON: May I have a motion
24 to approve Project 14-024, DaVi ta Stony Creek

**SUBSEQUENT TO INITIAL REVIEW -- 08/27/2014
DAVITA STONY CREEK DIALYSIS**

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1 Dialysis, for a 12-station end stage renal dialysis
2 facility in Oak Lawn.

3 MEMBER BRADLEY: So moved.

4 MEMBER PENN: Second.

5 CHAIRPERSON OLSON: State Board staff
6 report, please, George.

7 MR. ROATE: Thank you, Madam Chair.

8 The Applicants are proposing to discontinue
9 an existing 12-station renal dialysis facility located
10 on South Cicero Avenue in Oak Lawn and reestablish
11 this 12-station dialysis facility on West 95th Street
12 approximately 1.3 or 3.5 minutes apart.

13 The proposed facility will be in 7,733 gross
14 square feet, and the anticipated project cost is
15 \$3.2 million. The expected completion date is
16 February 29th, 2016.

17 Thank you, Madam Chair.

18 CHAIRPERSON OLSON: Are there questions
19 or comments from Board members?

20 (No response.)

21 CHAIRPERSON OLSON: I would just like to
22 note that -- have you confirm that your current
23 utilization at this facility is 95.83 percent. Is
24 that correct?

**SUBSEQUENT TO INITIAL REVIEW -- 08/27/2014
DAVITA STONY CREEK DIALYSIS**

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1 MR. SHEETS: That's the average.

2 I think the most recent is 91.8. The
3 average over the last eight quarters, though, is
4 over 95.

5 CHAIRPERSON OLSON: So over 90 percent.

6 MEMBER GREIMAN: I have a question.

7 CHAIRPERSON OLSON: Yeah, Justice.

8 MEMBER GREIMAN: What -- this is beyond
9 this particular issue, but what percentage of the
10 renal centers does DaVi ta have and what percentage, if
11 you know, does the other one, Fresenius, have?

12 MS. COOPER: I can't speak on behalf of
13 Fresenius because we haven't done the research, but
14 I would say, statewide, DaVi ta has somewhere around
15 40 percent.

16 MEMBER GREIMAN: 40?

17 MS. COOPER: Over in Chicago it's a much
18 lower percentage.

19 MEMBER GREIMAN: So 40 -- they have
20 53 percent, they said, and you have 40.

21 MS. COOPER: I haven't done the actual
22 numbers but --

23 MEMBER GREIMAN: That's 93 percent is
24 owned by two -- by two operations in the whole state,

SUBSEQUENT TO INITIAL REVIEW -- 08/27/2014
DAVITA STONY CREEK DIALYSIS

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1 93 percent.

2 MS. COOPER: I would like to say,
3 without -- without having done research on that
4 specific issue, I think that's sort of -- that's my
5 understanding as far as DaVi ta's ownership.

6 MEMBER GREIMAN: That's fair.

7 I'm just saying it's -- I'm wondering if
8 there -- we don't have antitrust laws for medical
9 institutions, but maybe we should have. But okay.

10 MR. SHEETS: Well, Judge, really what
11 happens is these companies end up buying out the other
12 companies so . . .

13 MEMBER GREIMAN: I understand.

14 CHAIRPERSON OLSON: Okay. Other
15 questions --

16 MEMBER GREIMAN: What would we do if
17 General Motors bought all the automobile people out?

18 You know.

19 CHAIRPERSON OLSON: Other questions or
20 comments by Board members?

21 (No response.)

22 CHAIRPERSON OLSON: Seeing none, I would
23 ask for a roll call vote.

24 MR. AGBODO: Thank you, Madam Chair.

**SUBSEQUENT TO INITIAL REVIEW -- 08/27/2014
DAVITA STONY CREEK DIALYSIS**

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1 Motion made by Mr. Bradley; seconded by
2 Mr. Penn.
3 Mr. Bradley.
4 MEMBER BRADLEY: Yes.
5 MR. AGBODO: Dr. Burden.
6 MEMBER BURDEN: Yes.
7 MR. AGBODO: Senator Demuzio.
8 MEMBER DEMUZIO: Yes.
9 MR. AGBODO: Justice Greiman.
10 MEMBER GREIMAN: Reluctantly, yes.
11 MR. AGBODO: Mr. Hayes.
12 VICE CHAIRMAN HAYES: Yes.
13 MR. AGBODO: Mr. Penn.
14 MEMBER PENN: Yes.
15 MR. AGBODO: Mr. Sewell.
16 MEMBER SEWELL: Yes.
17 MR. AGBODO: Madam Chair Olson.
18 CHAIRPERSON OLSON: Yes.
19 MR. AGBODO: 8 votes in the affirmative.
20 CHAIRPERSON OLSON: The motion passes.
21 Thank you.
22 MR. SHEETS: Thank you very much.
23 MS. COOPER: Thank you.
24 MEMBER BRADLEY: Can I just make

**SUBSEQUENT TO INITIAL REVIEW -- 08/27/2014
DAVITA STONY CREEK DIALYSIS**

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1 one comment?

2 CHAIRPERSON OLSON: Sure.

3 MEMBER BRADLEY: Given what's going on
4 in health care, I think it might be wise for us to
5 start monitoring what percent of the beds in Illinois
6 that general hospital systems have because we're going
7 to see fewer and fewer hospitals.

8 MEMBER GREIMAN: Right. We are.

9 MEMBER BRADLEY: It would be interesting
10 to take a look at that at some point.

11 MR. AGBODO: Okay.

12 MR. SHEETS: Thank you.

13 MS. COOPER: Thank you.

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SUBSEQUENT TO INITIAL REVIEW -- 08/27/2014
ADVOCATE BROMENN MEDICAL CENTER

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1 CHAIRPERSON OLSON: Okay. Next, we have
2 Project I-01 -- I'm sorry -- Project H-06, Advocate
3 BroMenn Medical Center in Normal.

4 Is Advocate at . . . would you please state
5 your name and be sworn in by the court reporter.

6 MS. REECE: Sonja Reece, R-e-e-c-e.

7 MR. PINNEKE: Steve Pinneke,
8 P-i-n-n-e-k-e.

9 MR. OURTH: And Joe Ourth, O-u-r-t-h.

10 The COURT REPORTER: Would you raise
11 your right hands, please.

12 (Three witnesses duly sworn.)

13 THE COURT REPORTER: Thank you. And
14 please also print your names, if you would.

15 CHAIRPERSON OLSON: May I have a motion
16 to approve Project 14-027, Advocate BroMenn Medical
17 Center, to approve a relocation/modernization of the
18 pharmacy?

19 MEMBER SEWELL: So moved.

20 MEMBER PENN: So moved.

21 VICE CHAIRMAN HAYES: Second.

22 CHAIRPERSON OLSON: State Board staff
23 report.

24 MR. ROATE: Thank you, Madam Chair.

**SUBSEQUENT TO INITIAL REVIEW -- 08/27/2014
ADVOCATE BROMENN MEDICAL CENTER**

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1 The Applicant proposes to relocate its
2 pharmacy department into shell space established
3 through an earlier construction/expansion project.

4 The anticipated cost of the project is
5 \$2 million, and there's an anticipated completion date
6 of March 31st, 2016.

7 Board staff reports no findings and no
8 opposition to the project, and the purpose of the
9 project is to meet the need of the US Pharmacopeia
10 compendium of standards of medication preparation now
11 enforced by the US Food and Drug Administration.

12 Thank you, Madam Chair.

13 CHAIRPERSON OLSON: Thank you, George.
14 Questions for the Applicant?

15 (No response.)

16 CHAIRPERSON OLSON: Seeing none, I would
17 ask for a roll call vote on Project 14-027.

18 MR. AGBODO: Thank you, Madam Chair.

19 The motion was made by Mr. Penn; seconded by
20 Mr. Hayes.

21 Mr. Bradley.

22 MEMBER BRADLEY: Yes.

23 MR. AGBODO: Dr. Burden.

24 MEMBER BURDEN: Yes.

**SUBSEQUENT TO INITIAL REVIEW -- 08/27/2014
ADVOCATE BROMENN MEDICAL CENTER**

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1 MR. AGBODO: Senator Demuzio.

2 MEMBER DEMUZIO: Yes.

3 MR. AGBODO: Justice Greiman.

4 MEMBER GREIMAN: Yes.

5 MR. AGBODO: Mr. Hayes.

6 VICE CHAIRMAN HAYES: Yes, based on the
7 State Board staff report.

8 MR. AGBODO: Thank you.

9 Mr. Penn.

10 MEMBER PENN: Yes.

11 MR. AGBODO: Mr. Sewell.

12 MEMBER SEWELL: Yes, for reasons stated
13 by Mr. Hayes.

14 MR. AGBODO: Thank you.

15 Madam Chair Olson.

16 CHAIRPERSON OLSON: Yes, for reasons
17 stated.

18 MR. AGBODO: 8 votes in the affirmative.

19 CHAIRPERSON OLSON: The motion passes.

20 Good Luck.

21 MS. REECE: Thank you.

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1 CHAIRPERSON OLSON: Okay.

2 So let's flip back to the beginning of the
3 agenda . . .

4 MEMBER SEWELL: Madam Chair, I think
5 that last project -- I think I made the motion.

6 I don't think Mr. Penn --

7 CHAIRPERSON OLSON: Well, I think you
8 did it simultaneously.

9 MEMBER SEWELL: Oh, did we?

10 CHAIRPERSON OLSON: You didn't get
11 credit for it.

12 MEMBER SEWELL: I didn't hear his voice.

13 MR. AGBODO: I heard both.

14 CHAIRPERSON OLSON: That's fine.

15 MR. AGBODO: Okay. Thank you.

16 CHAIRPERSON OLSON: Equal opportunity.

17 Okay. We will now go back to the beginning
18 of the agenda, and Item 3 is executive session.

19 May I have a motion to go into closed
20 section -- closed session -- pursuant to
21 Sections 2(c)(1), 2(c)(5), 2(c)(11), and 2(c)(21) of
22 the Open Meetings Act.

23 May I have a motion.

24 MEMBER DEMUZIO: Motion.

**REPORT OF PROCEEDINGS -- 08/27/2014
POSTPERMIT ITEMS**

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1 VICE CHAIRMAN HAYES: Second.

2 CHAIRPERSON OLSON: All those in favor
3 say aye.

4 (Ayes heard.)

5 CHAIRPERSON OLSON: Opposed, nay.

6 (No response.)

7 CHAIRPERSON OLSON: We are now in
8 executive session. We anticipate the executive
9 session will last about an hour.

10 (At 9:43 a.m., the Board adjourned
11 into executive session. Open
12 session proceedings resumed at
13 10:33 a.m., as follows:)

14 CHAIRPERSON OLSON: We're going to go
15 back into open session.

16 Our next item, we'd like to do postpermit
17 items approved by the Chairman.

18 George.

19 MR. ROATE: Thank you, Madam Chair.

20 Madam Chair, we only have one item, and that
21 was a permit renewal for Project No. 12-102, DaVi ta
22 West Side Dialysis in Chicago. They requested a
23 six-month permit renewal which you've approved.

24 CHAIRPERSON OLSON: Thank you.

**REPORT OF PROCEEDINGS -- 08/27/2014
POSTPERMIT ITEMS**

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Any questions or comments about that?

(No response.)

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**REPORT OF PROCEEDINGS -- 08/27/2014
PINCKNEYVILLE COMMUNITY HOSPITAL**

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1 CHAIRPERSON OLSON: Okay. Next, we'll
2 move on to items for State Board action.

3 09-068, Pinckneyville Community Hospital,
4 Pinckneyville, for a 12-month renewal from
5 October 1st, 2014, to October 1st, 2015.

6 May I have a motion for a 12-month
7 approval -- permit renewal for Pinckneyville Community
8 Hospital?

9 VICE CHAIRMAN HAYES: So moved.

10 MEMBER BURDEN: Second.

11 MEMBER BRADLEY: Second.

12 CHAIRPERSON OLSON: This, again, a
13 project with no opposition and no findings.

14 And my extreme apologies to Pinckneyville
15 for not calling you before the executive section.
16 That's my fault.

17 MR. URSO: Board members, I just wanted
18 to remind you to please explain your votes and give a
19 reason why you are voting the way you are voting.

20 Thank you.

21 CHAIRPERSON OLSON: Can we get you
22 gentlemen sworn in, please.

23 The COURT REPORTER: Raise your right
24 hands, please.

**REPORT OF PROCEEDINGS -- 08/27/2014
PINCKNEYVILLE COMMUNITY HOSPITAL**

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1 (Two witnesses duly sworn.)

2 THE COURT REPORTER: Thank you.

3 And please state your names and print your
4 names, as well.

5 MR. HUDGINS: My name is Thomas Hudgins.
6 I'm the CEO of Pinckneyville Community Hospital.

7 MR. PARKHURST: Ed Parkhurst, Prism
8 Healthcare Consulting.

9 CHAIRPERSON OLSON: Thank you.
10 George, State Board staff report.

11 MR. ROATE: Thank you, Madam Chair.

12 MEMBER GREIMAN: Is there something
13 wrong with the electricity in this joint?

14 I cannot hear today.

15 CHAIRPERSON OLSON: You have to hold the
16 microphone very close to your mouth.

17 MR. HUDGINS: Okay.

18 MEMBER GREIMAN: Still no.

19 CHAIRPERSON OLSON: Is it on?

20 MS. AVERY: Yeah. I think that turned
21 them off.

22 MR. HUDGINS: Is that better?

23 MS. AVERY: Yeah.

24 MR. HUDGINS: That's as loud as it gets.

**REPORT OF PROCEEDINGS -- 08/27/2014
PINCKNEYVILLE COMMUNITY HOSPITAL**

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1 I'll speak up.

2 MS. AVERY: Is that better?

3 MR. URSO: You need to speak right in
4 there, like a rapper, how they hold it right there,
5 you know.

6 MR. HUDGINS: Is that better?

7 Sorry. We're a cappella.

8 CHAIRPERSON OLSON: Okay.

9 George, State Board staff report.

10 MR. ROATE: Thank you, Madam Chair.

11 On April 20th, 2010, the State Board
12 approved Project 09-068, which authorized the
13 establishment of a 25-bed critical access hospital in
14 Pinckneyville. On September 12th, 2012, the State
15 Board approved an alteration for this permit, reducing
16 its size and project cost.

17 This latest permit renewal request is for a
18 12-month extension of the project completion date,
19 from October 1st, 2014, to October 1st, 2015. The
20 permit holders state adverse weather conditions slowed
21 the construction. Construction is proceeding
22 according to schedule.

23 Thank you, Madam Chair.

24 CHAIRPERSON OLSON: Thank you, George.

**REPORT OF PROCEEDINGS -- 08/27/2014
PINCKNEYVILLE COMMUNITY HOSPITAL**

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1 Are there questions or comments from the
2 Board on this permit?

3 MEMBER SEWELL: I have a question of the
4 staff.

5 MR. ROATE: Sure.

6 MEMBER SEWELL: This mention in the
7 State agency report of designation as a necessary
8 provider of health care, would you say a little bit
9 about that.

10 That's not the same thing as a critical
11 access hospital?

12 MR. ROATE: Technically, as far as it
13 being a necessary provider, you're saying there's a
14 difference between necessary provider --

15 MEMBER SEWELL: No. I just wasn't
16 familiar with this designation. I mean, that's some
17 formal designation by --

18 MR. ROATE: No, sir. I think it just
19 mimics the critical access hospital designation.

20 MEMBER SEWELL: Yeah, that's what I
21 thought. Okay.

22 MR. ROATE: Thank you, sir.

23 CHAIRPERSON OLSON: Other questions?
24 Comments?

**REPORT OF PROCEEDINGS -- 08/27/2014
PINCKNEYVILLE COMMUNITY HOSPITAL**

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1 MEMBER GREIMAN: Yeah.

2 CHAIRPERSON OLSON: Justice.

3 MEMBER GREIMAN: Have you discontinued
4 the 25 beds that were -- that you had before?

5 MR. HUDGINS: We have reduced the bed
6 complement from 25 to 18 -- to 17. Looking at our
7 future need, we did not need 25 beds, and that took
8 about a half million dollars out of the project.

9 MEMBER GREIMAN: So you're saying that
10 there still is a hospital in Pinckneyville?

11 MR. HUDGINS: Yeah, there is one right
12 now. The one we are constructing to replace it will
13 have fewer beds but more space for outpatient
14 services.

15 MEMBER GREIMAN: Right. But, you know,
16 the problem, of course, is that this started in
17 April 2010 and now it's -- it's -- now it's 2014.

18 MR. HUDGINS: Yes. The one thing we've
19 run into is financing, which some of the other Board
20 members who have been here through this are aware of.

21 And we thought we had financing lined up in
22 2010 with Housing and Urban Development, and they
23 decided, late in the year of 2010, not to fund the
24 project. We've been working with USDA since March of

**REPORT OF PROCEEDINGS -- 08/27/2014
PINCKNEYVILLE COMMUNITY HOSPITAL**

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1 2012 and received a commitment letter from them in
2 August of last year and got our notice to proceed in
3 February of 2014.

4 The financing delay has caused a slowdown in
5 the start of the project, also.

6 MEMBER GREIMAN: So you're comfortable
7 with the finance arrangement?

8 MR. HUDGINS: Yes. The financing is in
9 place. USDA has committed and the money is there for
10 us to finish the project, and we anticipate being done
11 in May of next year, occupied during the summer, and
12 have all the necessary filings completed and back to
13 the Board prior to the October 1 date --

14 MEMBER GREIMAN: Thank you. I hope
15 I don't see you next May.

16 CHAIRPERSON OLSON: Any other questions
17 or comments?

18 (No response.)

19 CHAIRPERSON OLSON: Seeing none, I would
20 ask for a roll call vote on Project 09-068,
21 Pinckneyville Community Hospital in Pinckneyville.

22 MR. AGBODO: Thank you, Madam Chair.

23 The motion was made by Mr. Hayes. I really
24 don't know who seconded.

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1 CHAIRPERSON OLSON: Who seconded?

2 MEMBER BURDEN: (Indicating.)

3 CHAIRPERSON OLSON: Justice -- the
4 doctor.

5 MR. AGBODO: Thank you.

6 So motion made by Mr. Hayes; seconded by
7 Dr. Burden. I'm sorry.

8 Mr. Bradley.

9 MEMBER BRADLEY: Yes.

10 MR. AGBODO: Dr. Burden.

11 MEMBER BURDEN: Yes. Because
12 I recognize the struggle that it's been for the
13 community institution to provide hospital care, and
14 they've done a very lengthy, tedious -- lengthy is
15 understanding -- understandably is the short word --
16 it's really been a long process for you folks and
17 I concur.

18 I vote yes.

19 MR. AGBODO: Thank you.

20 Senator Demuzio.

21 MEMBER DEMUZIO: Yes. I concur with
22 Dr. Burden.

23 MR. AGBODO: Justice Greiman.

24 MEMBER GREIMAN: I'm going to vote yes.

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1 But I would express my concern that projects
2 ought not to take -- projects of this nature -- ought
3 not to take six years for finishing. And I think it
4 affects the community; it affects the delivery of
5 health care in the community.

6 But I'll vote aye.

7 MR. AGBODO: Okay.

8 Mr. Hayes.

9 VICE CHAIRMAN HAYES: Yes, for reasons
10 stated.

11 MR. AGBODO: Mr. Penn.

12 MEMBER PENN: Yes, for reasons stated.

13 MR. AGBODO: Mr. Sewell.

14 MEMBER SEWELL: Yes, for reasons stated.

15 MR. AGBODO: Madam Chair Olson.

16 CHAIRPERSON OLSON: Yes, based on the
17 positive State Board staff report.

18 MR. AGBODO: 8 votes in the affirmative
19 and 1 absent.

20 CHAIRPERSON OLSON: Thank you.

21 Motion passes.

22 Good luck to you.

23 MR. HUDGINS: Thank you.

24 We'd like to express our appreciation to the

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1 Board and the staff for their understanding in this
2 process.

3 CHAIRPERSON OLSON: Thank you.

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VICTORIAN VILLAGE**

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1 CHAIRPERSON OLSON: Next, I would call
2 Project 08-082, Victorian Village, Homer Glen, for a
3 three-month renewal from September 30th, 2014, to
4 December 31st, 2014.

5 May I have a motion to approve a three-month
6 permit renewal for Victorian Village in Homer Glen?

7 MEMBER GREIMAN: So moved.

8 MEMBER DEMUZIO: Motion.

9 MEMBER GREIMAN: Second.

10 CHAIRPERSON OLSON: Motion and second.

11 MR. AGBODO: Thank you.

12 CHAIRPERSON OLSON: Would the Applicant
13 please be sworn in.

14 And I do apologize to you gentlemen, too.
15 I should have called you before the executive session.
16 I'm very sorry.

17 The COURT REPORTER: Raise your right
18 hands, please.

19 (Three witnesses duly sworn.)

20 THE COURT REPORTER: Thank you.

21 And please state your names and print your
22 names.

23 MR. OURTH: Joe Ourth, O-u-r-t-h.

24 MR. HEMPHILL: Ray Hemphill with

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1 Providence Life Services.

2 MR. COURTNEY: Jeff Courtney with
3 Providence Life Services.

4 THE COURT REPORTER: Thank you.

5 CHAIRPERSON OLSON: State Board staff
6 report, please.

7 MR. ROATE: Thank you, Madam Chair.

8 On September 1st, 2009, the State Board
9 approved Project 08-082, authorizing the establishment
10 of a 50-bed skilled nursing facility in Homer Glen.
11 The State agency notes the project is obligated and
12 the current project completion date is September 30th,
13 2014.

14 The Applicants are before us today to
15 request a three-month permit renewal from
16 September 30th, 2014, to December 31st, 2014. The
17 Board staff notes this is the fourth permit renewal
18 request for this permit holder and the reason for this
19 latest request is to allow sufficient time for IDPH's
20 nursing/licensure inspection to occur.

21 Thank you, Madam Chair.

22 CHAIRPERSON OLSON: So the project is
23 virtually completed and is just waiting for IDPH to --

24 MR. OURTH: Yes. As Jeff could explain,

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1 the Village certificate of occupancies have been
2 issued. Furniture moves in in a couple of weeks, and
3 they expect to have the first resident in within a
4 couple of months.

5 So as Mr. Roate said, it is simply the
6 process for the IDPH inspection and approval.

7 CHAIRPERSON OLSON: Other Board
8 questions or comments?

9 (No response.)

10 CHAIRPERSON OLSON: Seeing none, I'll
11 ask for a roll call vote of Project 08-082, Victorian
12 Village, Homer Glen, for a three-month renewal.

13 MR. AGBODO: Thank you, Madam Chair.

14 The motion was made by Senator Demuzio;
15 seconded by Justice Greiman.

16 Mr. Bradley.

17 MEMBER BRADLEY: Based on the State
18 agency report, I vote yes.

19 MR. AGBODO: Dr. Burden.

20 MEMBER BURDEN: Yes.

21 MR. AGBODO: Thank you.

22 Senator Demuzio.

23 MEMBER DEMUZIO: Yes.

24 MR. AGBODO: Justice Greiman.

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1 MEMBER GREIMAN: Yes.
2 MR. AGBODO: Mr. Hayes.
3 VICE CHAIRMAN HAYES: Yes, based on the
4 State agency report.
5 MR. AGBODO: Mr. Penn.
6 MEMBER PENN: Yes, based on the State
7 agency report.
8 MR. AGBODO: Mr. Sewell.
9 MEMBER SEWELL: Yes, for three more
10 months.
11 MR. AGBODO: Madam Chair Olson.
12 CHAIRPERSON OLSON: Yes, based on the
13 State Board staff report's positive findings.
14 MR. AGBODO: 8 votes in the affirmative.
15 CHAIRPERSON OLSON: Motion passes.
16 Again, I'm sorry for holding you up.
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1 CHAIRPERSON OLSON: Now we will go back
2 to . . . a one-second break.

3 (Discussion off the record.)

4 CHAIRPERSON OLSON: We're going to make
5 another minor adjustment to the agenda.

6 We're going to go through the executive
7 session motions, and then we will be hearing public
8 participation from the individuals that are testifying
9 on Carle Hospital's project, and then we will actually
10 hear that project at that point.

11 Is Carle here?

12 (No response.)

13 CHAIRPERSON OLSON: Is Carle Hospital
14 here?

15 UNIDENTIFIED FEMALE: Yes.

16 CHAIRPERSON OLSON: Okay.

17 Compliance issues and settlement
18 arrangements and final orders.

19 Frank.

20 MR. URSO: Thank you, Madam Chair.

21 Can you hear me?

22 The first item is Westmont Nursing & Rehab
23 Center. I'm requesting a motion to refer this matter
24 to legal counsel for review and filing of any notices

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1 for noncompliance, which may include sanctions
2 detailed and specified in the Board's Act and the
3 rules.

4 Can I have a motion to approve that
5 referral, please?

6 CHAIRPERSON OLSON: May I have a motion?

7 VICE CHAIRMAN HAYES: So moved.

8 CHAIRPERSON OLSON: Second?

9 MEMBER SEWELL: Second.

10 MEMBER BURDEN: Second.

11 CHAIRPERSON OLSON: All those in favor
12 say aye.

13 (Ayes heard.)

14 CHAIRPERSON OLSON: Opposed, nay.

15 (No response.)

16 CHAIRPERSON OLSON: The motion passes.

17 MR. URSO: Thank you, Madam Chair.

18 The next item, I would like a motion to
19 adopt the Administrative Law Judge's May 28th, 2014,
20 recommendation that the Board render a final decision,
21 administrative decision, to deny the application for
22 the certificate of need as the Board's final decision
23 for the Manor Care Health Services of Crystal Lake
24 project, 12-39, which is Docket No. HFSRB 13-1.

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1 I'm requesting a motion to adopt the
2 Administrative Law Judge's decision to affirm the
3 denial of that long-term care facility.
4 MEMBER DEMUZIO: Motion.
5 CHAIRPERSON OLSON: May I have a motion?
6 MEMBER BURDEN: Second.
7 MEMBER SEWELL: Second.
8 CHAIRPERSON OLSON: Who seconded?
9 MEMBER SEWELL: (Indicating.)
10 CHAIRPERSON OLSON: May I have a roll
11 call vote, please, Nelson.
12 MR. AGBODO: Yes, Madam Chair.
13 The motion was made by Senator Demuzio;
14 seconded by . . .
15 CHAIRPERSON OLSON: Mr. Sewell.
16 MR. AGBODO: Oh, Mr. Sewell.
17 Mr. Bradley.
18 Mr. Bradley.
19 MEMBER BRADLEY: Yes.
20 MR. AGBODO: Yes?
21 MS. AVERY: Sorry.
22 MR. AGBODO: Thank you.
23 Dr. Burden.
24 MEMBER BURDEN: Yes.

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1 MR. AGBODO: Senator Demuzio.
2 MEMBER DEMUZIO: Yes.
3 MR. AGBODO: Justice Greiman.
4 MEMBER GREIMAN: Yes.
5 MR. AGBODO: Mr. Hayes.
6 VICE CHAIRMAN HAYES: Yes.
7 MR. AGBODO: Mr. Penn.
8 MEMBER PENN: Yes.
9 MR. AGBODO: Mr. Sewell.
10 MEMBER SEWELL: Yes.
11 MR. AGBODO: Madam Chair Olson.
12 CHAIRPERSON OLSON: Yes.
13 MR. AGBODO: 8 votes in the affirmative.
14 CHAIRPERSON OLSON: The motion passes.
15 MR. URSO: Thank you, Madam Chair and
16 Board members.
17 I'm now requesting a motion for final
18 decision on the Board versus Claridge Health Care
19 Center. This is a default final decision whereby the
20 \$4,000 fine is due immediately.
21 CHAIRPERSON OLSON: Okay. May I have a
22 motion?
23 MEMBER PENN: Motion.
24 CHAIRPERSON OLSON: Second?

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1 MEMBER SEWELL: Second.

2 VICE CHAIRMAN HAYES: Second.

3 CHAIRPERSON OLSON: All those in favor
4 say aye.

5 (Ayes heard.)

6 CHAIRPERSON OLSON: Opposed, nay.

7 (No response.)

8 CHAIRPERSON OLSON: Motion passes.

9 MR. URSO: And that was Docket
10 No. HFSRB 13-08.

11 The next request I have for a motion is to
12 approve the final decision on Terrace on the Park,
13 Health Facilities and Services Review Board Docket
14 No. 13-14 [sic] for Permit 11-121, requesting a
15 default final decision, and the fine is now
16 immediately due.

17 CHAIRPERSON OLSON: May I have a motion?

18 MEMBER DEMUZIO: Motion.

19 MEMBER BURDEN: Yes -- second.

20 CHAIRPERSON OLSON: Motion by Demuzio;
21 second by the doctor.

22 Can I have a voice vote, please? All those
23 in favor say aye.

24 (Ayes heard.)

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1 CHAIRPERSON OLSON: Opposed, nay.

2 (No response.)

3 CHAIRPERSON OLSON: Motion passes.

4 MR. URSO: Thank you, Board members and
5 Madam Chair.

6 The next item I have for a final decision
7 approval is the Lisle Center for Pain Management,
8 being 55-555, LLC, Permit No. 11 dash -- 11-121 --
9 excuse me -- and Docket No. HFSRB 13-14.

10 That's a motion to accept the settlement
11 proposal and motion for a final order.

12 CHAIRPERSON OLSON: May I have a motion?

13 MEMBER SEWELL: So moved.

14 VICE CHAIRMAN HAYES: Second.

15 MEMBER PENN: Second.

16 MR. AGBODO: Mr. Bradley.

17 MEMBER BRADLEY: Yes.

18 CHAIRPERSON OLSON: We can -- I'm just
19 going to do a voice vote on that one, too.

20 All those in favor say aye.

21 (Ayes heard.)

22 CHAIRPERSON OLSON: Opposed, nay.

23 (No response.)

24 CHAIRPERSON OLSON: Motion passes.

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1 MR. URSO: Madam Chair, let me just
2 correct that.

3 Terrace on the Park does not have a permit
4 number, so I want to make sure we have a correct
5 record on that.

6 The next item is a motion to close the file
7 on the Sacred Heart Hospital in Chicago, Illinois.
8 It's Docket No. HFSRB 14-06, and this is a motion to
9 close the file regarding the above-captioned facility
10 and that no further proceedings regarding this
11 facility closing without a permit will be reviewed.

12 CHAIRPERSON OLSON: May I have a motion?

13 MEMBER GREIMAN: Let me -- can --

14 CHAIRPERSON OLSON: Yes.

15 MEMBER GREIMAN: So you feel that we've
16 done -- there's a bankruptcy in this case?

17 CHAIRPERSON OLSON: Yeah.

18 MEMBER GREIMAN: Was -- this was the
19 case with the bankruptcy?

20 MR. URSO: That is correct, Judge.

21 MEMBER GREIMAN: And have we not filed
22 a -- either -- a filing in the bankruptcy case?

23 MR. URSO: We've had conversations with
24 the Attorney General's office, and the Board has not

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1 formally been listed as a creditor.

2 MEMBER GREIMAN: Why don't we just file
3 as a creditor? Why don't we file a complaint here in
4 the Bankruptcy Court?

5 MR. URSO: If the Board would like,
6 I can check with the Assistant Attorney General, see
7 if the timing is correct to do that, and if we have an
8 opportunity, we will.

9 MEMBER GREIMAN: Makes sense to me to
10 do it.

11 CHAIRPERSON OLSON: Do we still close
12 the file or do we withdraw?

13 MEMBER BRADLEY: That's what I was
14 getting at earlier but nobody -- Frank said we were
15 too far down the list to have any result. But . . .

16 MEMBER GREIMAN: Well, I don't know.
17 Maybe that's true. And if it is, that's okay. Let's
18 forget it.

19 CHAIRPERSON OLSON: So I have a motion
20 and a second.

21 Do we have a motion and a second?

22 MR. URSO: No, we don't.

23 CHAIRPERSON OLSON: Okay.

24 May I have a motion and a second to close

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1 the file?

2 MEMBER DEMUZIO: Motion.

3 MEMBER SEWELL: Second.

4 CHAIRPERSON OLSON: Okay. So I'm going
5 to do a roll call on this one. And if it doesn't
6 pass, we'll regroup.

7 So roll call, please.

8 MR. AGBODO: Motion made by Senator
9 Demuzio; second by Mr. Sewell.

10 Mr. Bradley.

11 MEMBER BRADLEY: Yes.

12 MR. AGBODO: Dr. Burden.

13 MEMBER BURDEN: Yes.

14 MR. AGBODO: Senator Demuzio.

15 MEMBER DEMUZIO: Yes.

16 MR. AGBODO: Justice Greiman.

17 MEMBER GREIMAN: Present.

18 MR. AGBODO: Present.

19 Mr. Hayes.

20 VICE CHAIRMAN HAYES: Yes.

21 MR. AGBODO: Mr. Penn.

22 MEMBER PENN: Yes.

23 MR. AGBODO: Mr. Sewell.

24 MEMBER SEWELL: Yes.

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1 MR. AGBODO: Madam Chair Olson.

2 CHAIRPERSON OLSON: Yes.

3 MR. AGBODO: So I have 7 votes in the
4 affirmative, 1 present, 1 absent.

5 CHAIRPERSON OLSON: The motion passes.

6 MR. URSO: Thank you, Board members and
7 Madam Chair.

8 I request now a final decision for the Board
9 versus Grand Oaks Ambulatory Surgical Treatment
10 Center. It's docketed as HFSRB 14-09.

11 This deals with Project No. 03-054,
12 requesting a final default judgment decision in this
13 particular matter.

14 CHAIRPERSON OLSON: May I have a motion,
15 please.

16 MEMBER PENN: Motion.

17 MEMBER GREIMAN: Second.

18 CHAIRPERSON OLSON: All those in favor
19 say aye.

20 (Ayes heard.)

21 CHAIRPERSON OLSON: Opposed, nay.

22 (No response.)

23 CHAIRPERSON OLSON: The motion passes.

24 MR. URSO: Thank you.

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APPROVAL OF MINUTES**

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1 The next item is Daystar Nursing & Rehab
2 Center, Docket No. HFSRB 14-11, requesting approval of
3 a final order.

4 They paid their fine and submitted the
5 necessary information on Daystar Nursing & Rehab
6 Center.

7 CHAIRPERSON OLSON: May I have a motion?

8 VICE CHAIRMAN HAYES: So moved.

9 MEMBER PENN: Second.

10 MEMBER SEWELL: Second.

11 CHAIRPERSON OLSON: All those in favor
12 say aye.

13 (Ayes heard.)

14 CHAIRPERSON OLSON: Opposed, nay.

15 (No response.)

16 CHAIRPERSON OLSON: Motion passes.

17 MR. URSO: Thank you, Madam Chair.

18 I believe that's all I have at this time.

19 MEMBER SEWELL: Madam Chair.

20 CHAIRPERSON OLSON: Yes.

21 MEMBER SEWELL: Never mind.

22 CHAIRPERSON OLSON: The next item on the
23 agenda is the approval of the minutes.

24 May I have a motion to approve the minutes

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1 of July 14th, 2014?

2 VICE CHAIRMAN HAYES: So moved.

3 MEMBER PENN: Second.

4 CHAIRPERSON OLSON: Moved and seconded.

5 All those in favor say aye.

6 (Ayes heard.)

7 CHAIRPERSON OLSON: Opposed, nay.

8 (No response.)

9 CHAIRPERSON OLSON: The minutes of the
10 July 14th meeting are approved.

11 The next order of business is public
12 participation. As stated, we will be hearing from
13 Carle Clinic first.

14 We are, as was posted on our website,
15 limiting public participation today to one minute. We
16 have 65 people signed up for public participation.

17 At the one-minute mark, I will loudly bang
18 the gavel and you'll be asked to stop immediately.
19 We need to move this along today since there are so
20 many.

21 Please be reminded that there are
22 opportunities for public participation at hearings and
23 we do want your voice to be heard, but in this case
24 we're going to have to limit the comments just

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1 slightly.

2 So don't come up, Carle Clinic. We have to
3 do the public participation things first.

4 So would you please call the first five
5 names -- and, Nelson, if you'll give me the high sign.

6 MR. AGBODO: Yes, I will.

7 MS. AVERY: Okay.

8 We have Jennifer Eardley, Phil Blankenburg,
9 Russ Leigh, Michael Zia, and Don Annis, A-n-n-i-s.

10 CHAIRPERSON OLSON: The court reporter
11 has also asked that you state your name clearly and
12 sign in on the pad.

13 The names that were called may come to the
14 table.

15 MS. FRIEDMAN: Could I just . . .
16 sidebar?

17 (Discussion off the record.)

18 CHAIRPERSON OLSON: Okay. Please state
19 your name and -- one minute.

20 DR. EARDLEY: Hello. My name is
21 Jennifer Eardley. I'm here on behalf of the
22 University of Illinois at Urbana-Champaign to express
23 the university's continued strong support for Carle
24 Foundation Hospital's Project No. 14-015.

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1 Our chancellor, Phyllis Wise, has submitted
2 a written letter of support that is on file with the
3 Board.

4 The university and Carle have embarked upon
5 a project that we believe will support and accelerate
6 growth of subspecialty care and, consequently, demand
7 for hospital beds at Carle.

8 We're excited about our partnership to
9 explore the creation of an engineering-focused medical
10 school. This project will facilitate recruitment of
11 physicians like Dr. Graham Huesmann, a neurologist who
12 brought much needed epilepsy care to the Urbana-
13 Champaign community. With his assistance the
14 university is also bringing new imaging technology to
15 Carle that would not have been possible without his
16 expertise.

17 We are excited by the promise this example
18 demonstrates and firmly believe that our partnership
19 with the college of medicine will continue to grow
20 recruitment of new subspecialties, resulting in
21 continued demand for the unique services Carle offers
22 and, subsequently, for hospital beds.

23 Thank you for the opportunity to express our
24 support for this project.

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1 CHAIRPERSON OLSON: Well done.

2 Thank you.

3 Next.

4 MR. ANNIS: Hello. My name is
5 Don Annis. I'm the chief executive officer of
6 Crawford Memorial Hospital, about 100 miles from
7 Champaign-Urbana, down in southern Illinois.

8 I'm here to urge all members of the Illinois
9 Health Facilities and Services Review Board to support
10 Carle Foundation's request.

11 I appreciate the Board staff's report
12 delineating -- delineation of Carle's tertiary care
13 programs which provide critical services which are not
14 available closer to Crawford.

15 Based on the critical access hospital
16 designation, my hospital in Crawford is limited in the
17 acuity level of patients that we serve, that we care
18 for based on primary care hospitals. It is essential
19 to understand why we rely on Carle as a tertiary care
20 facility that provides advanced care for us.

21 Crawford and Carle have worked closely
22 together for more than 25 years, and we expect that
23 reliance on Carle to only increase. The process of
24 transferring patients to Carle, from our experience,

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1 is very efficient and well coordinated. Carle is
2 truly our safety net hospital.

3 There are times when we must transfer a
4 patient who needs immediate care and send that patient
5 to the nearest acute hospital, but often we have
6 complex cases --

7 MR. AGBODO: One minute.

8 MR. ANNIS: -- that must go to Carle.

9 We thank you for supporting their
10 application.

11 CHAIRPERSON OLSON: Thank you.

12 Next.

13 DR. ZIA: I'm Dr. Michael Zia, chief
14 medical officer at Decatur Memorial Hospital, and
15 I come to support this proposal.

16 We rely on Carle's recognized expertise for
17 many services, their stroke, neurosurgery, trauma,
18 ortho trauma, high-risk neonatal, and maternal care.
19 Carle is our designated regional trauma center and the
20 only hospital in Champaign-Urbana where we refer
21 patients for admission.

22 Let me provide one example: Carle supports
23 Decatur Memorial's patients who need a neurologist.
24 Our emergency physicians can immediately communicate

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1 with a specialist.

2 It would not be in the best interests of
3 these patients to send them to another facility when
4 Carle physicians are already involved. If the patient
5 has complex needs, the Carle specialist has the
6 patient's history, and this allows for a more
7 efficient, seamless transfer of that patient.

8 Decatur has specialist physicians on staff.
9 In critical situations a patient should not have to
10 wait while DMH attempts to locate an alternative
11 hospital simply because Carle does not have space.

12 This is not just a Champaign-Urbana
13 question. Your decision affects my patients --

14 MR. AGBODO: One minute.

15 DR. ZIA: -- and my health care access.

16 Thank you.

17 CHAIRPERSON OLSON: Thank you, Doctor.

18 MR. LEIGH: My name is Russ Leigh. I'm
19 the board chair of the Hoopston Regional Health
20 Center.

21 I support the project proposed by Carle to
22 add beds to improve access to health care for
23 residents of my community and throughout central
24 Illinois. I provided support testimony in the last

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1 hearing when this project was before you. I want this
2 Board to know that my support is unwavering.

3 I'm a lifelong resident of Vermilion County.
4 This area has critical need for a strong surgery and
5 care partner for our acutely ill patients, which is
6 one of the factors driving the growth of Carle's
7 medical /surgical unit.

8 For over 20 years I've been on the board of
9 the local critical access hospital and am witness to
10 the increased demand for Carle's hospital services.
11 This year Hoopston Regional Health Center is on pace
12 to increase transfers by 10 percent, which is
13 consistent with the trends of other outlying
14 hospitals. Let this serve as evidence of the need for
15 these beds.

16 The role of a small community hospital has
17 shifted to providing core inpatient services and
18 serving as a medical home for patients. If Carle must
19 divert these rural patients, we'd need more time to
20 obtain treatment and higher potential for a bad
21 outcome.

22 I ask you to approve Carle's proposal so
23 that residents in Hoopston and similar communities
24 can receive the advanced care they need.

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1 CHAIRPERSON OLSON: Thank you.

2 Next.

3 MR. BLANKENBURG: Thank you. Good
4 morning.

5 My name is Phil Blankenburg and I'm from
6 Monticello. As a former mayor of Monticello and a
7 former board member of Kirby Hospital and a current
8 board member of The Carle Foundation, I feel I have a
9 unique perspective in understanding that we are
10 fortunate to have Kirby Medical Center and local
11 doctors to address primary health needs in Piatt
12 County; however, when a serious illness or trauma
13 requires a higher level of care, those in our
14 communities rely on Carle.

15 Carle can provide consulting, accept
16 transfers, and later transition the patient back home
17 for care. Partnerships like this are crucial to rural
18 areas.

19 There have been claims that there are beds
20 available in the area at Presence Hospital and other
21 hospitals, but what needs to be clear is that the beds
22 must be available 24/7 with appropriate physician and
23 staff coverage. In reality, when a bed isn't
24 available in Carle, what happens more frequently is

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1 that a patient must travel or be transitioned at least
2 90 miles to get the same level of care and
3 specialists.

4 There is an important place for community
5 hospitals like Kirby in Monticello, Paris Community
6 Hospital, and Crawford Memorial, but when these needs
7 arise --

8 MR. AGBODO: One minute.

9 MR. BLANKENBERG: -- those in my
10 community and others and thousands rely upon Carle.

11 I urge you to approve this proposal so that
12 we can get the care we need.

13 Thank you.

14 CHAIRPERSON OLSON: Thank you.

15 MS. AVERY: Okay. Thanks.

16 Next up is Leland Phipps, Bill Manning,
17 Marty Edwards, Chris Blue, Scott Pittman.

18 Someone can start before everybody signs in.

19 DR. PHIPPS: Yes, ma'am.

20 My name is Dr. Lee Phipps. I'm the chief of
21 staff at Paris Community Hospital. We're a critical
22 access hospital. I've been there for three decades or
23 more.

24 We rely on Carle greatly for our specialty

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1 care because it is not available locally. Over the
2 past 30 years, they have earned the right to see my
3 patients. Not everyone gets that right.

4 And they've done this through the quality of
5 their care, their expertise, and their maintenance of
6 cutting-edge technology, including but not limited to
7 the new transvenous valvular repair, which has
8 revolutionized the care of valvular heart disease and
9 congestive failure from our patients. For the same
10 care my fellows would have to go to either St. Louis
11 or to Indianapolis, and for some of my people, because
12 of their age, their infirmity, that would be care
13 denied, and that obviously is not what any of us want
14 here.

15 I realize bricks and mortar don't make the
16 institution, but without the bricks and mortar, with
17 this age of increasing demand, we will not be able to
18 guarantee access to my patients.

19 MR. AGBODO: One minute.

20 DR. PHIPPS: So my reason for being here
21 is very self-serving: My folks need it. So I would
22 hope you accept.

23 CHAIRPERSON OLSON: Thank you, Doctor.

24 Next.

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1 MS. EDWARDS: Good morning. I'm Marty
2 Edwards. I live in Champaign and I have volunteered
3 at Carle Foundation Hospital for 12 years.

4 I ask you to approve Carle's certificate of
5 need application so Carle can fulfill its important
6 role in the region as a tertiary care provider.

7 One of my responsibilities at Carle is to
8 greet patients and visitors coming from as far north
9 as Kankakee and as far south as Vincennes, Indiana.
10 They come because their local hospital referred them
11 to Carle for highly specialized care. No other
12 hospital in the region offers advanced specialties and
13 has remained as committed to investing in technology
14 and training.

15 We are lucky to have this resource,
16 particularly in light of the charity care the hospital
17 provides to members of the immediate community as well
18 as to residents of outlying areas.

19 I heard the opposition of this project
20 request and disagree with their opinions. Carle
21 provides lifesaving treatment to people who
22 desperately need it. A local mayor's philosophical
23 objection to a hospital's nonprofit status --

24 MR. AGBODO: One minute.

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1 MS. EDWARDS: -- should not factor into
2 your decision today.

3 CHAIRPERSON OLSON: Please conclude your
4 remarks.

5 MS. EDWARDS: The legislature
6 specifically provided that clarification. If this
7 Board --

8 CHAIRPERSON OLSON: Please conclude --

9 MS. EDWARDS: -- approves an
10 application --

11 CHAIRPERSON OLSON: Please conclude your
12 remarks.

13 MS. EDWARDS: -- that outlines the
14 need --

15 CHAIRPERSON OLSON: Please conclude your
16 remarks.

17 MS. EDWARDS: I'm sorry?

18 CHAIRPERSON OLSON: I need you to
19 conclude your remarks. Your time's up.

20 MS. EDWARDS: Thank you.

21 MS. BLUE: My name is Christina Blue.
22 I have recently --

23 MEMBER GREIMAN: Use the microphone.

24 MS. BLUE: -- recently survived a

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1 serious heart attack. And because of the doctors and
2 care I received at Carle Foundation Hospital, I'm able
3 to be here today --

4 MR. URSO: Could you move that
5 microphone closer, please, ma'am? Because we can't
6 hear you.

7 CHAIRPERSON OLSON: Put your mouth right
8 next to the microphone.

9 MS. BLUE: -- I am able to be here today
10 to speak in support of Carle's proposal to add beds
11 and expand services to care for people who need
12 hospital treatment.

13 About a month ago I experienced a major
14 heart attack which involved the widow maker artery,
15 considered the worst of heart attacks and often the
16 culprit of a sudden death.

17 I live in Olivet in rural Vermilion County.
18 Once we determined I was having a heart attack, my
19 husband called 911. The ambulance arrived and
20 transported me to the nearest hospital, Presence
21 United Samaritans.

22 The doctors did X-rays and a CAT scan and
23 told my family, with my best interests in mind, they
24 were transferring me to another hospital because it

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1 was more than they could handle in Danville. We asked
2 to be transferred to Carle.

3 When I arrived at Carle Foundation Hospital,
4 the doctor was dressed and waiting. He immediately
5 began the procedure to insert stents. I had no idea
6 how bad the heart attack was until later. I was never
7 afraid because we were kept informed along the way,
8 and I received the best care.

9 I am now participating in cardiac
10 rehabilitation --

11 MR. AGBODO: One minute.

12 MS. BLUE: -- at the Carle Heart and
13 Vascular Institute, knowing Carle's advanced level of
14 care and expertise isn't available anywhere else.

15 I urge you to --

16 CHAIRPERSON OLSON: Please conclude your
17 remarks.

18 MS. BLUE: -- support The Carle
19 Foundation's proposal.

20 CHAIRPERSON OLSON: Thank you.

21 Next.

22 MR. PITTMAN: Scott Pittman, Georgetown,
23 Illinois, in support of Project No. 14-015.

24 This summer my 2-year-old son sustained a

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1 traumatic brain injury when a steel rail from the back
2 of a trailer hit him. It was immediately clear he had
3 a serious head injury, and EMS advised he needed to be
4 transported directly to Carle Foundation Hospital,
5 bypassing the nearest hospital in Danville. His
6 injuries included a fractured skull, severe
7 concussion, and a gash in his forehead.

8 Many die from a traumatic brain damage and
9 many more have survived and have lasting neurological
10 deficiencies. Now, two months later, our son --
11 perhaps miraculously and in large part due to the care
12 that he received at Carle -- seems to be back to
13 normal. I couldn't be more grateful.

14 We received the best care from a great team
15 of neurologists, trauma doctors, therapists, and more.
16 Having this team available around the clock gave him
17 the best possible outcome.

18 Our son Jacob celebrated his third birthday
19 last night. I'm grateful every day to know that,
20 because of the level of care that Carle Foundation
21 Hospital was able to provide, we were able to
22 celebrate with him.

23 I strongly urge this Board to approve the
24 request to add beds at Carle so families like ours can

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1 receive the same advanced care, not available
2 elsewhere in the region.

3 CHAIRPERSON OLSON: Thank you all.
4 Next.

5 MS. AVERY: Next is Collin Anderson,
6 Janelle Reilly, Chuck Bohlmann, and Dr. Tangella,
7 Shawn Albritton.

8 CHAIRPERSON OLSON: You may start.
9 Please speak right into the microphone.

10 MR. ANDERSON: My name is Collin
11 Anderson, testifying on behalf of Janet Gravelin of
12 Urbana, who was unable to be here today.

13 In her absence Janet asked me to read her
14 entire testimony; however, in the interest of time,
15 I will simply state that her testimony echoes a letter
16 to the editor that was published in the Champaign-
17 Urbana News Gazette on August 13th.

18 In that letter she described how her husband
19 arrived at the emergency department of Presence
20 Covenant only to be told -- only to be transferred to
21 Carle Hospital because Presence did not have a
22 neurosurgeon available to care for his brain
23 hemorrhage.

24 She expressed that she remains grateful

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1 Carle had the necessary specialists and capacity to
2 provide lifesaving treatment.

3 Thank you.

4 CHAIRPERSON OLSON: Thank you.

5 Next.

6 MS. REILLY: Good morning. My name is
7 Janelle Reilly. I'm the chief operating officer for
8 Presence Health.

9 Thank you for the opportunity to speak in
10 opposition to Carle's plans to add 48 acute care beds.

11 First, Carle's project is an expansion of an
12 existing service requiring referral letters from
13 physicians. No such letters were provided.

14 Therefore, the impact on other facilities hasn't been
15 quantified for your decision-making process.

16 The additional 40 patients a day that Carle
17 is using as justification have to come from somewhere,
18 and if they come from Presence Covenant, it will be
19 devastating.

20 Second, I refer you to the utilization table
21 in your staff report. It projects bed need based on
22 both medical/surgical and observation days.

23 Carle has 26 observation beds in addition to
24 its 212 beds. The need for med/surg beds should

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1 logically be based on med/surg utilization alone. It
2 is not.

3 Third, adding acute care beds is contrary to
4 national and regional trends. A recent study by
5 Kaufman Hall projects a 23 percent decline in acute
6 care admissions due to the shift from inpatient care
7 to outpatient settings in the greater Chicagoland
8 area.

9 MR. AGBODO: One minute.

10 MS. REILLY: Thank you for your remarks.

11 CHAIRPERSON OLSON: Thank you.

12 Next.

13 MR. ROATE: May I interject, Madam

14 Chair?

15 CHAIRPERSON OLSON: Yes.

16 MR. ROATE: If you haven't had a chance
17 to sign in, please do so.

18 CHAIRPERSON OLSON: Thank you, George.

19 MR. ROATE: Thank you.

20 MR. BOHLMANN: Hi. My name is

21 Chuck Bohlmann. I'm the president and CEO of Iroquois
22 Memorial Hospital in Watseka, about 45 miles northeast
23 of Urbana, and I'm here to highlight the effect this
24 proposal might have on smaller communities like ours.

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1 In Watseka recently we experienced Carle
2 directing primary care physicians to give up their
3 privileges at our hospital. Their patients were sent
4 letters indicating that they would now be hospitalized
5 in Carle facilities instead.

6 I don't believe rerouting primary care
7 patients to Urbana and Hoopston, patients who could
8 have been cared for in Watseka, is in the best
9 interests of those patients and their families. We do
10 transfer patients to both Carle and Presence Covenant
11 when specialty services are needed as well as bringing
12 in specialists from those facilities to our hospital,
13 but I think there are better options to collaborate on
14 how to meet the basic med/surg needs of patients in
15 our region than by adding beds at Carle.

16 I respectfully urge the Board to deny this
17 application.

18 CHAIRPERSON OLSON: Thank you.

19 Next.

20 DR. TANGELLA: Good morning. My name is
21 Krish Tangella. I'm the regional medical director for
22 laboratory services for both United Samaritans Medical
23 Center in Danville and to Presence Covenant Medical
24 Center in Urbana.

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1 Unlike most markets, where physicians are on
2 medical staff at more than one hospital, in our
3 community Carle physicians only admit to a Carle
4 facility with the only exception being the psychiatric
5 service line.

6 As a clinical physician -- the other
7 clinical physicians in the area have privileges both
8 at Carle and at Presence Hospital in an attempt to
9 give the patients and the community the choice, the
10 choice of hospitals. Because Carle physicians do not
11 practice at Presence Covenant, there is no choice for
12 the consumer. They must be hospitalized at Carle.

13 Should Carle be allowed to add beds when we
14 have capacity at other regional local hospitals in our
15 market, I'm concerned that the end result will be the
16 lack of hospital choice for all patients and our
17 community.

18 I sincerely and respectfully urge that the
19 Board deny this application for extra beds.

20 CHAIRPERSON OLSON: Thank you, sir.

21 Next.

22 MR. ALBRITTON: Hi. I'm Shawn
23 Albritton, speaking on behalf of Dr. Janice Bahr,
24 professor of physiology at the University of Illinois.

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1 Professor Bahr had to leave to go teach a noon class.

2 "I will speak to four areas that demonstrate
3 the importance of Presence Covenant to the university.

4 "First, undergraduates. As a faculty
5 member, I have had many undergraduates gaining
6 clinical experience at Covenant prior to entering
7 medical school.

8 "Second, we have a strong medical scholars
9 program at the university, and I have served as a
10 mentor to many of the med students who, during
11 clinical training at Covenant, had the opportunity to
12 be fully participatory in a faith-based and inclusive
13 environment.

14 "Third, the clinical residency experience
15 for internal medicine residents at Covenant is
16 invaluable.

17 "And, finally, as a researcher in
18 physiology, specifically ovarian cancer, availability
19 of tissue and access to patients allows us to
20 translate basic research into clinical relevancy.

21 "I urge the Board to consider the
22 implications for the university as well as the broader
23 community of any decision which allows expansion for
24 one hospital at the expense of the community but

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1 potentially leaving fewer options and less access to
2 care.

3 "Thank you."

4 CHAIRPERSON OLSON: Thank you.

5 MR. URSO: You can leave if you've all
6 spoken.

7 CHAIRPERSON OLSON: You may be
8 dismissed.

9 (Discussion off the record.)

10 CHAIRPERSON OLSON: Next, we're going to
11 hear public participation -- Carle's not ready so
12 we're going to hear public participation on 14-013,
13 University of Chicago Medical Center CCD build-out.

14 Would you please call them.

15 MS. AVERY: Okay.

16 Leslee Spencer, Patricia Wood, Michelle
17 Hannon, Duane Oest, O-e-s-t.

18 Oh, Gloria Funderburg.

19 CHAIRPERSON OLSON: Yes, please hold the
20 microphone close.

21 MR. OEST: Hello. My name is
22 Duane Oest. I represent myself.

23 I'm a south sider by birth and a hospital
24 patient for cancer twice. In 2006 I spent 10 days in

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1 Mitchell Hospital. During that time my wife and I sat
2 in a dated waiting room just prior to my major surgery
3 and, following that surgery, my wife spent the first
4 two nights balanced across two metal chairs trying to
5 get some sleep. Water-stained ceilings, worn and
6 cluttered narrow halls made my recovery walking
7 difficult if not impossible.

8 This past June I spent five days in the CCD
9 following surgery for a different type of cancer.
10 Without a roommate my recovery went a whole lot
11 quicker, half the interruptions, half the noise.
12 I recovered quicker and was actually discharged
13 two days earlier.

14 During my stay -- and I walked the halls --
15 because you're supposed to do that after the
16 surgery -- and I saw a patient base and a group of
17 caregivers that truly reflected Chicago. They were
18 black, white, brown, Asian -- this is a Chicago
19 hospital, not the white hospital in a black area of
20 the city.

21 MR. AGBODO: One minute.

22 MR. OEST: This hospital is now centered
23 on the patient.

24 Please allow the hospital to complete the

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1 transformation. The neighborhood and the patients
2 like me will be the better for it.

3 CHAIRPERSON OLSON: Thank you.

4 Next.

5 MS. SPENCER: Good afternoon. My name
6 is Leslee Stein Spencer, and I'm with the Chicago Fire
7 Department. I'm in charge of medical administration
8 regulatory compliance.

9 One of my roles in this position is to
10 monitor transport times and response times for the
11 Chicago Fire Department and also look at bypass.
12 Bypass is when a hospital's too full, can no longer
13 take ambulance services.

14 Prior to them adding 38 beds, the University
15 of Chicago was one of our leaders in bypass. We were
16 not able to transport there. Since the addition they
17 have decreased their hours on bypass by over
18 80 percent.

19 In addition, we transport to the University
20 of Chicago as a specialty center. Two years ago we
21 started transporting to STEMI centers and -- which are
22 heart attack centers and stroke centers. University
23 of Chicago has been the leader for the most transports
24 for stroke patients and for STEMI patients, heart

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1 attack patients. Without these additional beds, we
2 will lose that capacity to transport patients that
3 need these critical aspects of care.

4 And, finally, the number of transports that
5 the Chicago Fire Department did to the University of
6 Chicago in 2012 was 7,020 patients, in 2013 it was
7 7,980 patients --

8 MR. AGBODO: One minute.

9 MS. SPENCER: -- and, now, 5,800, so we
10 need them.

11 Thank you.

12 CHAIRPERSON OLSON: Thank you.

13 MS. WOODS: Patricia Woods.

14 As a Chicago Fire Department member, we
15 would support this project.

16 CHAIRPERSON OLSON: Thank you.

17 MS. HANNON: Michelle Hannon.

18 As a Chicago Fire Department member, I, too,
19 support this.

20 CHAIRPERSON OLSON: Thank you.

21 MS. FUNDERBURG: My name is -- my name
22 is Gloria Funderburg, and I support the University of
23 Chicago.

24 My father was a cancer patient there, and he

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1 was there for treatment for lung cancer and pain
2 management. He stayed on the -- on the fifth floor on
3 the east where the rooms were dark or drab and kind of
4 really tight. And due to his pain and his level of
5 his condition, it was really hard to get around. It
6 was very cramped in that space.

7 On his next stay he was in the CCD building,
8 where -- and he was in a different room on the
9 10th floor. The view was beautiful; he was able to
10 get around; it wasn't hard for us to visit with the
11 social worker as we needed to -- social worker,
12 family, patient -- counseling that we needed.

13 So I support what they're doing. I support
14 it. It made him much happier, more comfortable,
15 because family could stay with him throughout that
16 hard and troubled time.

17 CHAIRPERSON OLSON: Thank you.

18 MS. AVERY: Okay. Next up we have
19 Rita Lanier, Dr. Puri, and Andrea -- and I think this
20 is P-o-a-c-d-i-n-o.

21 MS. LANIER: Good morning. My name is
22 Rita Lanier. I am a clinical nurse leader at the
23 University of Chicago Medical Center.

24 MEMBER GREIMAN: Microphone on your

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1 mouth.

2 MS. LANIER: Providing unsurpassed care
3 of each patient and their family is our ultimate
4 mission as a nurse and as clinicians at the University
5 of Chicago Medical Center. That's why our new Center
6 for Care and Discovery serves as the core of our
7 entire medical campus. It's not just another
8 beautiful building. It's a beautiful new idea in
9 providing the best clinical care.

10 This new hospital facility was designed by
11 colleagues of mine and by nursing staff members to
12 keep continually evolving and transforming as rapidly
13 as the forefront of medicine itself keeps constantly
14 changing.

15 As both an architectural and technology --
16 technological tour de force, the Center for Care and
17 Discovery is unique. It offers a healing and
18 therapeutic environment to our patients and their
19 families --

20 MR. AGBODO: One minute.

21 MS. LANIER: -- during their most
22 vulnerable times of their lives.

23 Thank you.

24 CHAIRPERSON OLSON: Thank you.

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1 DR. PURI: Good morning. My name is
2 Dr. Tipu Puri. I'm a physician member of the faculty
3 at the University of Chicago. I've been practicing as
4 a board-certified nephrologist at the University of
5 Chicago for the past 10 years.

6 The University of Chicago physicians who
7 practice at the medical center are very enthusiastic
8 about this project, to build out two floors of shell
9 space in the Center for Care and Discovery. Put
10 simply, we believe this project will allow us to
11 provide better care for our sickest patients.

12 One of the challenges that our physicians
13 have faced since the opening of the Center for Care
14 and Discovery has been trying to efficiently manage
15 our most acutely ill patients in two locations that
16 are separated by over a quarter of a mile. This is a
17 particular issue for our ICU patients who are
18 currently being managed in two buildings with the care
19 required needing frequent evaluation and modification
20 by our physicians.

21 Being at the bedside or in close proximity
22 to our ICU patients is fundamental to their care.
23 Having critically ill patients under your care at
24 another building 10 minutes away is a major source of

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1 concern to our critical care patients.

2 These challenges are also faced with non-ICU
3 patients. Typically when physicians make rounds, we
4 decide the order by which patients need to be seen
5 based on clinical needs. Which patient is sicker?
6 Which patient has questions and concerns that need to
7 be addressed? Which patient is waiting for me so they
8 can be discharged?

9 MR. AGBODO: One minute.

10 DR. PURI: Having patients in two
11 buildings now adds a very inconvenient component of
12 location into our approach. The proposed project will
13 allow us -- will allow our most acutely ill patients,
14 both ICU and non-ICU --

15 CHAIRPERSON OLSON: Please conclude your
16 remarks.

17 DR. PURI: -- to be consolidated into
18 one building and will allow us to deliver better
19 patient care.

20 Thank you.

21 CHAIRPERSON OLSON: Thank you.

22 MS. PALADINO: Good morning -- or good
23 afternoon. My name is Andrea Paladino. I'm here as a
24 nurse representative for the University of Chicago.

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1 On behalf of both the adult cardiac cath
2 lab, the adult electrophysiology lab, the adult
3 cardiac ICU, the fifth-floor telemetry unit, and the
4 third-floor short stay unit, I'm here with numbers and
5 statistics, which is basically how health care is
6 measured these days, unfortunately.

7 What we see on a day-to-day basis in the
8 cardiac cath lab are STEMI patients, mechanical
9 support patients, patients in need of the right heart
10 cath and biopsies.

11 In the first six months of 2014, we've had
12 47 semiactivation patients, we've had 18 mechanical
13 support patients, we've had 42 patients that have come
14 to see us for Impella intra-aortic balloon pump
15 services, and 19 TAVR patients, which is transaortic
16 valve replacement or implant, based on your
17 experiences.

18 All of these patients traveled from the
19 fifth floor of the CCD to the fifth floor of the
20 Mitchell building. This is a half a mile. This
21 is 11 minutes on foot without a bed, 18 minutes
22 pushing a bed, 23 minutes pushing a bed with several
23 mechanical support devices attached.

24 MR. AGBODO: One minute.

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1 MS. PALADINO: We also do not fit in the
2 current elevators at the Mitchell Hospital, and
3 staying in Mitchell will ask -- we will request that
4 you build out further structures to support our
5 patient population.

6 CHAIRPERSON OLSON: Thank you.

7 (Discussion off the record.)

8 CHAIRPERSON OLSON: Okay. We're going
9 to go back to Carle. We skipped Dr. Jared Rogers.
10 My apologies.

11 Is the doctor in the house?

12 DR. ROGERS: (Indicating.)

13 CHAIRPERSON OLSON: Sorry about that.

14 DR. ROGERS: It's fine. Thank you.

15 CHAIRPERSON OLSON: Yes, please.

16 DR. ROGERS: Good morning.

17 I'm Dr. Jared Rogers, regional president and
18 CEO of Presence Covenant Medical Center and Presence
19 United Samaritans Medical Center.

20 I'm here to express my opposition to Carle's
21 certificate of need in a service area that's already
22 overbedded by 158 beds. The \$18 million price tag for
23 this expansion will inevitably be passed on to our
24 community in the form of higher medical costs.

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1 Second, Carle claims the additional beds are
2 for specialties not offered in the area by anyone
3 else. Actually, most of the specialty services in the
4 region are shared between Covenant and Carle, and
5 there is no distinction that exists in the provision
6 of the general medical care to patients.

7 Therefore, no justification has really been
8 provided for additional medical/surgical beds and
9 care, particularly in an era where care is moving from
10 the outpatient setting -- or moving to the outpatient
11 setting from the inpatient setting.

12 Third, expanding Carle at the expense of
13 other hospitals will deprive the community of choice
14 in health care. Carle is essentially not offering any
15 new services, only new costs to pay for health care.
16 This is simply not in the best interests of the
17 community.

18 Thank you.

19 CHAIRPERSON OLSON: Thank you, Doctor.

20 Okay. Next, we're going to move to
21 Project 14-021, Northwest Community Hospital,
22 John Dunkin, Michael Berkowitz, Arthur Skladman,
23 Bino Oommen, Janice Lau.

24 MS. AVERY: Okay. Anybody.

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1 CHAIRPERSON OLSON: Go ahead.

2 MR. DUNKIN: Good morning. My name is
3 John Dunkin. I'm the executive director for the
4 Rehabilitation Institute of Chicago at the Alexian
5 Rehabilitation Hospital.

6 Our hospital is a joint venture between the
7 Alexian Brothers Health System and Rehabilitation
8 Institute of Chicago, and through this partnership we
9 are able to bring the clinical expertise of a world-
10 class provider to the northwest suburbs. We operate
11 under protocols developed and used by the
12 Rehabilitation Institute of Chicago.

13 We have historically been privileged to
14 transfer -- have been a transfer site of approximately
15 90 percent of Northwest Community Hospital's patients
16 in the inpatient rehabilitation.

17 While we are the largest and busiest rehab
18 provider in the area, during the past year only
19 two transfers from Northwest Community Hospital were
20 delayed because we did not have an open bed.

21 Last year we added six new beds, and
22 our year-to-date occupancy rate is now 82 percent.
23 Even if one were to accept the demand numbers that
24 Northwest Community Hospital is proposing, there is

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1 already sufficient capacity in our program and other
2 programs in the area to address that demand.

3 Our physiatrists evaluate patients at
4 Northwest Community Hospital seven days of the week
5 and have done so for years. We also admit patients
6 seven days of the week. Last year 22 percent of our
7 transfers from Northwest Community Hospital occurred
8 on Saturday or Sunday --

9 MR. AGBODO: One minute.

10 MR. DUNKIN: -- and 52 percent of those
11 admissions occurred at one o'clock.

12 Thank you.

13 MR. ROATE: Madam Chair --

14 CHAIRPERSON OLSON: Yes.

15 MR. ROATE: -- may I remind those
16 speaking to please sign in.

17 CHAIRPERSON OLSON: Thank you, George.

18 Next.

19 MR. ROATE: Thank you.

20 DR. BERKOWITZ: Hello. My name is
21 Michael Berkowitz. I'm a board-certified physiatrist
22 for the Rehabilitation Institute of Chicago. I've
23 been in practice for 22 years with a general inpatient
24 and outpatient practice.

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1 I came here today to outline for you the
2 process that is used when evaluating a patient at
3 Northwest Community Hospital for potential placement
4 into a rehabilitative program.

5 Upon request from Northwest Community
6 Hospital, one of our psychiatrists evaluates the
7 patient's chart, performs a physical evaluation, and
8 recommends the appropriate level of rehabilitation
9 care, which may or may not be inpatient
10 rehabilitation.

11 Our psychiatrist gives his or her
12 recommendation to a Northwest Community Hospital case
13 manager, who then arranges an appropriate placement
14 and consultation with a patient's family.

15 When making a recommendation, we are
16 attempting to identify the inpatient or outpatient
17 rehabilitation setting that will result in the
18 greatest benefit to the patient. We use both
19 Medicare-developed standards and guidelines used by
20 all of RIC's programs as well as our own clinical
21 judgment when making recommendations for
22 rehabilitation settings. We believe this process to
23 be sound and one that results in the placement of
24 patients in the most clinically appropriate rehab

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1 setting.

2 We asked -- last year we were asked to
3 evaluate 350 patients at Northwest Community Hospital,
4 and approximately 60 percent of the patients that we
5 evaluated were transferred to an inpatient rehab unit.

6 Northwest Community Hospital recently
7 commissioned a survey --

8 MR. AGBODO: One minute.

9 DR. BERKOWITZ: -- to evaluate 2013 --
10 its 2013 patient population.

11 CHAIRPERSON OLSON: Please conclude your
12 remarks, Doctor.

13 DR. BERKOWITZ: Because of gross
14 disparity, we believe that Northwest Community's
15 program will not -- will impact existing providers'
16 utilization.

17 Thank you.

18 CHAIRPERSON OLSON: Thank you.

19 Next.

20 DR. OOMMEN: Good morning. My name is
21 Dr. Bino Oommen. I'm a primary care physician
22 affiliated with Northwest Community and Alexian
23 Brothers Hospital.

24 I want to speak of two specific delays and

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1 disposition of care that led to patient
2 dissatisfaction, placing letters to me.

3 Both patients were in their 80s, both
4 suffered from cardiac imbalance problems following a
5 stroke and were admitted to the ICU at Northwest.

6 Patient A was subsequently transferred to
7 the general medical floor and awaiting disposition to
8 transfer to Alexian. Four days passed since the
9 patient was transferred. The initial order was placed
10 on Wednesday; the patient was seen on Monday and
11 transferred on Tuesday.

12 The second patient required -- his physician
13 sent him to Alexian, a bed was not available,
14 subsequently had to go a nursing home to get acute
15 inpatient care equivalent to a nursing home standard
16 and subsequently transferred back to the hospital for
17 inpatient rehab. This was compromising patient care
18 because this was very disjointed.

19 Finally, I'd like to tell you that I train
20 10 miles to -- in distance -- to where I work
21 currently. I've seen a flawless system in place.
22 I'd highly recommend Northwest Community Hospital be
23 granted an inpatient rehab unit.

24 Thank you.

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1 CHAIRPERSON OLSON: Thank you.

2 Next.

3 MS. LAU: I am Janice Lau, stroke program
4 coordinator at Northwest Community Hospital.

5 CHAIRPERSON OLSON: You're going to have
6 to hold it.

7 MS. LAU: We offer an excellent service
8 of care for our stroke patients, from emergency EMS
9 services and plans into ED triage and treatment in our
10 award-winning stroke inpatient program, rehabilitation
11 program.

12 We offer a brain injury support group and
13 health and outpatient-based community services through
14 our hospital. Our link is broken because we do not
15 have acute rehab within our system. We have needed
16 the support of other organizations to render these
17 services for optimal care.

18 In the blink of an eye, our lives change
19 because of devastating illnesses. We witness waves of
20 emotions and uncertainty in the faces of stroke
21 survivors and their families.

22 Leaving the Northwest Community continuum of
23 care that we provide and having to find another
24 facility to provide this care is daunting. The link

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1 is broken. The continuity of acute rehab at Northwest
2 will provide our patients with the entire package of
3 services needed. They deserve this.

4 We are requesting this on behalf of every
5 patient. We are committed to the best outcome for all.
6 Thank you.

7 CHAIRPERSON OLSON: Thank you.

8 Next.

9 DR. SKLADMAN: Hello. My name is
10 Dr. Skladman. I'm -- for 28 years I've been an
11 internist on the staff of both Northwest Community
12 Hospital and Alexian Brothers Medical Center, and
13 I support the proposal to establish a small, inpatient
14 rehabilitation unit at Northwest Community Hospital.

15 I have had difficulties in getting my
16 patients admitted to Alexian Brothers for
17 rehabilitation. They're not just my patients at
18 Northwest Community Hospital but those who are my
19 patients at the Alexian Brothers Hospital.

20 When no rehabilitation beds at Alexian
21 Brothers are filled -- which is frequently the case --
22 even my patients at Alexian Brothers have to go
23 elsewhere for care. Quite frequently we have to admit
24 the patients to an extended care facility for subacute

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1 care. But that -- even more problematic for patients
2 at Northwest Community Hospital, the call was second
3 priority whether they have beds there at the time.

4 Having the unit within the Northwest
5 Community Hospital and more beds in that area would
6 avoid these problems. It would also enable physicians
7 to round on patients who have left our medical and
8 surgical floors for a comprehensive rehabilitation
9 unit.

10 MR. AGBODO: One minute.

11 DR. SKLADMAN: Our knowledge of their
12 conditions would benefit patients.

13 CHAIRPERSON OLSON: Please conclude your
14 remarks.

15 DR. SKLADMAN: Thank you for the
16 opportunity to speak on behalf of the project.

17 CHAIRPERSON OLSON: Thank you.

18 Next, we'll have Dina Lipowich, Brian
19 Samberg, Steve Samuelson, and Chris Budzinsky --
20 Budzinsky.

21 Please go ahead.

22 MS. BUDZINSKY: Good morning. I'm -- my
23 name is Christine Budzinsky. I'm a vice president
24 with Alexian Brothers Hospital network.

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1 I'm here to voice Alexian Brothers' strong
2 opposition to Northwest Community Hospital's proposal
3 to establish a comprehensive rehabilitation unit.

4 Alexian Brothers and the Rehabilitation
5 Institute of Chicago jointly operate Alexian Rehab
6 Hospital which, through the Rehabilitation Institute's
7 clinical direction, brings state-of-the-art rehab
8 services to the northwest suburbs. Our program is
9 located 12 minutes to the south of Northwest
10 Community. The project is absolutely unneeded. There
11 are no nonclinical barriers to the admission of
12 participation into our program, and none of the area
13 providers are operating at this Board's occupancy
14 target.

15 Integral to Northwest Community's
16 justification of its project is their representation
17 that they will continue referring patients to other
18 providers in the area, which they currently are. With
19 the established providers in the area unable to reach
20 a target occupancy level, you'd have to question how a
21 new provider would have so many patients that their
22 referral rates to other hospitals wouldn't drop.

23 Inpatient comprehensive rehabilitation is
24 not a service that needs to be provided by every

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1 hospital, and the close proximity of Northwest
2 Community to Alexian Brothers' --

3 MR. AGBODO: One minute.

4 MS. BUDZINSKY: -- existing program
5 would make approval of this project contrary to sound
6 health care planning principles.

7 CHAIRPERSON OLSON: Please conclude your
8 remarks.

9 MS. BUDZINSKY: We urge disapproval of
10 this project.

11 CHAIRPERSON OLSON: Thank you.

12 Next.

13 MR. SAMUELSON: Good morning -- good
14 morning. My name is Stephen Samuelson, president and
15 CEO of Frisbie Senior Center located in Des Plaines,
16 and I am here to speak in support of the Northwest
17 Community Hospital project.

18 Frisbie Senior Center offers social,
19 educational, and recreational activities for older
20 adults living in the northwest suburbs of Chicago, and
21 we also serve as a resource clearinghouse, connecting
22 individuals with organizations that provide much
23 needed services to older adults and children with
24 aging parents.

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1 Northwest Community Hospital continues to be
2 an excellent partner, offering financial support and a
3 variety of health and wellness programs at the center
4 for our members as well as the community at large.
5 These programs have included fall prevention, physical
6 therapy, and many others.

7 It is through this collaboration as well as
8 similar efforts with other community-based
9 organizations that I have come to know that outreach
10 and support are hallmarks of how NCH works to address
11 the various needs of the communities it serves.

12 At the center it is routine for us to learn
13 of our members recovering from joint replacement and
14 cardiac events and even stroke. A self-contained
15 continuum of care, including an inpatient physical
16 rehabilitation unit, will only aid in the efficient
17 treatment and speedy recovery of patients served,
18 especially with meeting the needs of the growing
19 population of seniors in northwest Cook County and
20 southern Lake County.

21 I fully support this project and urge
22 approval by the Health Facilities and Services Review
23 Board.

24 Thank you.

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1 CHAIRPERSON OLSON: Thank you.

2 Next.

3 MS. LIPOWICH: Good morning. My name is
4 Di na. I'm an advanced practice nurse and the director
5 of medical nursing and geriatric services at Northwest
6 Communi ty Hospi tal .

7 Recently a 64-year-old woman was brought to
8 Northwest Communi ty wi th --

9 THE COURT REPORTER: I'm sorry. "A
10 64-year-old woman" --

11 MS. LIPOWICH: A 64-year-old woman --

12 CHAIRPERSON OLSON: Closer to your
13 mouth.

14 MS. LIPOWICH: A 64-year-old woman was
15 brought to Northwest Communi ty Hospi tal wi th profound
16 stroke symptoms. She could not talk and had complete
17 right-sided paralysi s.

18 Her care in the ED required urgent
19 medicating rescue by our stroke team. With acute
20 intervention and care she was stabilized but now had
21 profound aphasi a and paralysi s. She could understand
22 language but no longer speak. She was weak and
23 required 24/7 medical care and rehabilitation.

24 The NCH discharge team took extraordinary

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1 measures to find an inpatient acute rehab that could
2 accommodate her needs. She met medical criteria for
3 acute rehabilitation. Unfortunately, she was not
4 accepted for acute rehab services because of her
5 self-pay status and lack of funds. Accordingly, the
6 patient was discharged to her daughter's home with NCH
7 home health. This care plan was far less than ideal
8 compared to what would be possible through intensive
9 therapy by specialized physicians and nursing staff.

10 As members of the --

11 MR. AGBODO: One minute.

12 MS. LIPOWICH: -- staff of Northwest
13 Community, we have seen and recognized the --

14 CHAIRPERSON OLSON: Please conclude your
15 remarks.

16 MS. LIPOWICH: -- effects of stroke on
17 patients and their families.

18 Thank you so much for your consideration.

19 CHAIRPERSON OLSON: Thank you.

20 Next.

21 MR. SAMBERG: Good morning. My name is
22 Brian Samberg. I'm the division vice president of
23 RehabCare, recently merged with Kindred Health.

24 I'm here to speak on --

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1 CHAIRPERSON OLSON: Please put the
2 microphone --

3 MR. SAMBERG: -- behalf of -- in support
4 of Northwest Community Hospital's project.

5 RehabCare and Kindred is the largest
6 provider of therapy services in the United States,
7 serving more than 500,000 patients last year, whom
8 over 43,000 were inpatients in comprehensive rehab
9 programs.

10 RehabCare manages seven programs in the
11 state of Illinois. I worked with Northwest Community
12 Hospital to apply the Medicare system of inpatient
13 rehabilitation codes and regs to determine the need
14 for comprehensive rehab services at Northwest
15 Community.

16 Our analysis concluded that 13 percent of
17 the 6,483 adult patients at Northwest Community
18 Hospital match the reg or 857 patients need inpatient
19 rehab in a hospital setting. Northwest Community,
20 on a conservative basis, used 10 percent in its
21 planning conversion factor, resulting in a need for
22 648 patients.

23 These 648 patients are sufficient not only
24 to fully occupy the 17-bed unit as proposed at the

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1 State's 85 percent occupancy level but still refer
2 over 300 -- 230 patients for comprehensive rehab at
3 other area hospitals.

4 This analysis on which the permit
5 application makes its case is a function of --

6 MR. AGBODO: One minute.

7 MR. SAMBERG: -- the impact on
8 providers.

9 Thank you for this opportunity.

10 CHAIRPERSON OLSON: Thank you.

11 Up next I'll call Marti Smith to the table,
12 speaking on Project 14-013, University of Chicago
13 Medical Center.

14 MS. SMITH: Chairwoman Olson, Board.

15 CHAIRPERSON OLSON: Please bring it
16 right next to your mouth.

17 MS. SMITH: I'm sorry?

18 CHAIRPERSON OLSON: Put the microphone
19 right next to your mouth. We can't hear many of you.
20 We need to hear you.

21 MS. SMITH: Chairman Olson, members of
22 the Board, we appreciate the opportunity to comment.

23 My name is Marti Smith. I represent the
24 National Nurses United, and we are here in opposition

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1 to the University of Chicago Medical Center, Project
2 No. 14-013.

3 Your staff report gives ample reasons for
4 denial of this. It does not meet medical -- the
5 regulatory requirements for the size of medical /
6 surgical rooms. But even more so -- and what's more
7 important to us -- is that this University of Chicago
8 Medical Center receives more than \$58 million per year
9 in tax breaks.

10 That's tax money taken from the community,
11 and the community is crying out for a trauma center.
12 University of Chicago Medical Center's response to
13 that is "It's complicated." In the meantime, they
14 spend 1.4 percent of their gross revenues on direct
15 care provided to the community members that they
16 purport to serve.

17 What the response -- what happens when there
18 is not a trauma center nearby is that people die. If
19 you have to travel more than 5 miles from where you
20 are --

21 MR. AGBODO: One minute.

22 MS. SMITH: -- sustaining a trauma to --

23 CHAIRPERSON OLSON: Please conclude --

24 MS. SMITH: -- to receive care, there's

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1 a 23 percent increased chance of mortality. That's
2 why this is important to us.

3 We respectfully ask you to deny it.

4 CHAIRPERSON OLSON: Thank you.

5 Frank, I think you have a statement to make,
6 and then I will be calling Carle Foundation Hospital
7 to the table, please.

8 MR. URSO: Thank you, Madam Chair.

9 I just want to remind Board members that,
10 you know, they receive a lot of testimony, a lot of
11 comments from the public, not only in public
12 participation, which you just heard, but also in
13 public hearing testimony and written comments.

14 I just want to remind all of you that all
15 that is done without an oath being taken by those
16 individuals. So you need to consider all that
17 information, but you also need to understand that all
18 that information is being provided without those
19 people being under oath.

20 The Board decision should be based upon the
21 Board's Act and the rules, and that's what contains
22 the criteria and the standards to be used by the Board
23 when they're making a decision.

24 Every application should be based on its own

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1 merits. The State Board report, which all of these
2 applications have, is an excellent source for you
3 Board members to review and to utilize when you're
4 taking your vote. The State Board report, as you
5 know, analyzes all of these applications and all of
6 this material and compares it to the Board's Act and
7 rules.

8 And, finally, I want to say, if there are
9 suggestions or ideas or comments that are made -- that
10 you hear in public participation or in public hearing
11 testimony or in written comments -- that you feel need
12 further clarification or elaboration, that's the time
13 for Board members to get back to the Board's staff
14 members and say, "We need more information on these
15 various questions that are being posed."

16 So if anybody has any questions, I'll be
17 glad to answer those, but I wanted to just remind
18 Board members that their decision should be based upon
19 the Act and the rules and they should give a basis and
20 rationale for every vote they take.

21 Thank you.

22 - - -

23
24

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1 CHAIRPERSON OLSON: Okay. The next
2 project is 14-015, Carle Foundation Hospital in
3 Urbana.

4 This project is -- may I have a motion to
5 approve Project 14-015, Carle Foundation Hospital, to
6 build out shell space and add 48 medical/surgical
7 beds?

8 MEMBER PENN: So moved.

9 CHAIRPERSON OLSON: And I'm going to
10 remind the Applicant to please, please put your
11 microphone right at your mouth and speak into it.
12 Much of what is being said today is difficult for the
13 court reporter to capture and for the Board members to
14 hear.

15 So please, please.

16 MEMBER PENN: So moved.

17 MEMBER BRADLEY: Second.

18 CHAIRPERSON OLSON: George, may we have
19 the State Board staff report?

20 MR. ROATE: Thank you, Madam Chair.

21 The Applicant, Carle Foundation, proposes to
22 add 48 medical/surgical beds to its existing 212-bed
23 complement, resulting in a total of 260 medical/
24 surgical beds.

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1 The estimated cost of the project is
2 \$17.8 million, and there's an anticipated project
3 completion date of January 31st, 2016.

4 Board staff notes the Applicant received an
5 intent to deny at the July 14th State Board meeting,
6 and in the report in front of you are only those
7 criteria that did not receive a positive finding in
8 the original State Board staff report.

9 Board staff also wishes to note the table on
10 page 3 contains bed utilization data that includes
11 observation days. The inclusion of observation days
12 in bed utilization is a standard practice for State
13 Board staff in the tabulation of bed utilization data.

14 Thank you, Madam Chair.

15 CHAIRPERSON OLSON: Would you --

16 MEMBER SEWELL: I have a question on the
17 State Board --

18 CHAIRPERSON OLSON: Can I get them sworn
19 in? And then we'll --

20 MEMBER SEWELL: Sure.

21 CHAIRPERSON OLSON: Could you please
22 state your names and be sworn in.

23 MS. FRIEDMAN: Madam Chair, Kara
24 Friedman, counsel for Carle Foundation Hospital.

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1 MS. BEEVER: Stephanie Beever, senior
2 vice president, strategic development, Carle
3 Foundation Hospital.

4 MR. HARDING: Scott Harding, vice
5 president, Carle Foundation Hospital.

6 MR. BILLIMACK: Mike Billimack, vice
7 president, Carle Foundation Hospital.

8 The COURT REPORTER: Would you raise
9 your right hands, please.

10 (Four witnesses duly sworn.)

11 THE COURT REPORTER: Thank you.

12 CHAIRPERSON OLSON: Mr. Sewell, you had
13 a question for --

14 MEMBER SEWELL: Yeah. It's about that
15 the State agency report -- can you hear me?

16 THE COURT REPORTER: Speak up, please --
17 just speak loud.

18 MEMBER SEWELL: All right.

19 In the reason for noncompliance in the State
20 agency report, you project the utilization, and you
21 make the statement that the 48 additional beds will be
22 needed by the second year after project completion --

23 MR. ROATE: Yes, sir.

24 MEMBER SEWELL: -- and I guess that's

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1 2017 or 2018.

2 MR. ROATE: Yes, sir.

3 CHAIRPERSON OLSON: What page are
4 you on?

5 MEMBER SEWELL: I'm on page 4 of the
6 State agency report.

7 What does the criterion say about trends and
8 projections? I'm just wondering why we said that.
9 I don't think I've ever seen that before.

10 MR. ROATE: While we cannot accurately
11 predict the future, Mr. Sewell, the -- by comparing
12 the patterns of growth in historical utilization data
13 and projecting it forward, this allows the Applicant
14 and State Board staff to somewhat develop a picture of
15 what looking at -- now, trends may not stick around
16 for the next two or three years, but based on
17 historical utilization data, it is projected forward
18 that there would be sufficient --

19 MEMBER SEWELL: I understand that but my
20 question is a little different.

21 Does the criterion have us look at whether
22 or not there is sufficient demand at the time of the
23 report? Or can we just pick a time, based on the
24 trends, and make a statement that, by some year in the

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1 future, it will be okay? That's what I'm questioning.

2 MR. ROATE: Usually by the year --
3 second year after project completion, the second
4 calendar year -- and you had mentioned 2017. The
5 project completion date we have slated is
6 January 31st, 2016.

7 So looking forward to 2017, it is assumed,
8 using that projected data, that there would be
9 sufficient bed need.

10 MEMBER SEWELL: I understand. But do we
11 normally do this?

12 MR. ROATE: Yes, sir.

13 MEMBER SEWELL: Okay.

14 CHAIRPERSON OLSON: Comments for the
15 Board from the Applicant, please.

16 MS. BEEVER: Good morning. Hi. I'm --
17 can you hear me okay?

18 Okay. Hi. I have a cold. I was trying to
19 stay away from everyone.

20 I am Stephanie Beever. I'm the senior vice
21 president for strategic development at Carle
22 Foundation Hospital.

23 I want to thank you all who came here today
24 to support our proposal and provide perspectives on

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1 the importance of this project to the communities that
2 Carle serves and validates Carle's role in our larger
3 region.

4 We presented our plan to validate our
5 hospital -- excuse me.

6 We presented our plan to add capacity to our
7 existing medical/surgical units to the Board members
8 who were able to attend the hearing last month, and we
9 appreciate the vocal support received from Mr. Olson
10 [sic], Greiman, Bradley, and Galassi.

11 We really appreciate the comments in the
12 updated Board staff report that recognized that we
13 play a different role in the region, as the only
14 Level I trauma center and a tertiary care facility in
15 south central Illinois and eastern Illinois. This
16 project is critical to our community, and we have a
17 responsibility to move forward with this project.

18 For those Board members who were not present
19 last month, I'm going to provide a very brief update.
20 Our med/surg beds are consistently full at this time.
21 In times of high census, we must refuse and transfer
22 patients to other facilities.

23 Usually the cases we receive from the
24 outlying facilities cannot be diverted to Presence

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1 Covenant due to the lack of the specialization that's
2 needed for those individual patients. Instead,
3 critical patients we cannot accommodate are typically
4 sent to Indianapolis, Peoria, or St. Louis due to some
5 of their subspecializations. We really need to add
6 beds to accommodate the demand.

7 Carle saw a 27 percent increase in our
8 medical/surgical census from 2010 to 2013 and has a
9 2013 medical/surgical occupancy rate of 93 percent.
10 That trend is continuing on into this year.

11 Before I continue, our legal counsel,
12 Kara Friedman, would like to bring your attention to
13 some key findings in the State agency report.

14 MS. FRIEDMAN: Thank you.

15 And I know that we just briefly touched on
16 some of this, so I'll try to keep it short. There are
17 several updates in the revised Board staff report that
18 I'd like to note.

19 On page 3 the Board staff report notes that,
20 for a proposal such as this one to expand bed category
21 of service in an existing hospital, the Board does --
22 the Board does not take into consideration the
23 calculated need or access to beds in the planning area
24 nor the utilization of other existing providers.

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1 While in the previous report excess beds in
2 the planning area were cited as a basis for a negative
3 finding, this is a finding that your staff adjusted to
4 positive after reassessing the applicable review
5 criteria. We are pleased to see that correction.

6 There's another clarification that they
7 made -- and there's a map on the back page of the
8 State agency report that is somewhat similar to this
9 but it's smaller. It really only demonstrates the
10 D-1 planning area, and I hope Mike here can let the
11 audience see that, as well.

12 Our staff has confirmed -- and this is on
13 page 3, again, of the State agency report -- that the
14 proposal complies with the requirement that at least
15 50 percent of the hospital's patient admissions come
16 from its immediate planning area, as is required by
17 our Section 1110.530.

18 I just want to point out to you -- it's hard
19 for me to talk and point at the same time.

20 So what you have here in the dark purplish
21 black is the D-1 planning area, and then the area
22 surrounding this is the region that we serve -- at
23 least the Illinois regions because there's also part
24 of Indiana that's served.

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1 So here you can see that, while 60 percent
2 does come from this immediate planning area, there's a
3 broader service area that we serve substantially. On
4 page 101 of the application we provided that data that
5 demonstrates that the majority of the patients do come
6 from this planning area.

7 And I think we failed -- and I'm sorry -- to
8 fully understand Board Member Sewell's questions from
9 the last meeting when he asked if we have a
10 disagreement with the Board's rules on this point. We
11 don't have a disagreement with their rules, and
12 I apologize if there was any confusion.

13 We comply with this criteria as D-1 is our
14 primary area; however, as the tertiary regional
15 referral area for this 40-county service area, it
16 admits patients for the whole region.

17 As to the issues raised by Presence last
18 submission, they were not new. On page 8 of the staff
19 report, the bottom, Board staff summarized key
20 objections and responded in support of this
21 application.

22 I won't touch on them any more because
23 I think George Roate did, but I think the staff
24 concurs that they're not relevant to our application,

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1 at least to that part that's cited there.

2 On page 2 of the executive summary of the
3 Board staff, staff notes that there appears to be no
4 equivalent provider in east central Illinois, and it's
5 this position in the larger health care system, along
6 with their large medical staff and deep bench of
7 specialists, which is driving its growth.

8 The staff report continues by reporting
9 that, if the hospital continues to experience the same
10 growth in demand it's recently experienced, the number
11 of beds requested will be needed. And as Stephanie
12 said, the growth trend has continued.

13 MS. BEEVER: In the mid-'90s -- to give
14 you a sense of how we even got to where we are
15 today -- Carle made an intentional decision to broaden
16 our specialty physician services while also continuing
17 to make sure there was a developed primary care base
18 in order to provide primary and tertiary care services
19 to a very broad geographic, which you have seen a part
20 of here today.

21 During that same period we also invested
22 significant capital dollars. On an annual basis our
23 system puts in 30 to \$35 million for our typical
24 capital projects in the system to keep us very

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1 relevant.

2 In addition, since 2007 we've brought a
3 variety of projects forward to you. One was a
4 five-bed inpatient unit expansion in our hospital;
5 another is, most recently, the heart and vascular
6 institute which you have seen.

7 In addition, we have put a substantial
8 capital dollar allocation into creating an integrated
9 medical record that is across all of our systems and
10 all of our locations, ambulatory and inpatient, which
11 leads us to be able to very effectively and
12 efficiently manage the patients' care.

13 We've developed dedicated technical teams to
14 support those complex loads of patients; in
15 particular, heart and vascular and neurosurgery are
16 examples that are unique in our particular market.

17 Based on the work -- this work we've done
18 and other trends, our medical center now serves as a
19 clinical safety net for 19 smaller critical access
20 hospitals and community hospitals in the map that you
21 just saw. Excuse me.

22 As you know, many of these hospitals in the
23 outlying areas have voiced their support for more beds
24 at Carle as they and their medical staff increasingly

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1 need to refer patients to Carle for admission. There
2 are only two other cities in downstate Illinois --
3 south of I-80 -- that have the tertiary care
4 capabilities that Carle happens to provide.

5 As a clinical safety net, we now employ
6 nearly 400 physicians, representing 50 different
7 specialties, have an integrated medical record, a
8 robust hospitalist system, and we're really focused on
9 efficiency of care in the right setting, whether
10 that's the hospital or the ambulatory setting or at
11 your community facility.

12 While we've invested in services and been
13 successful in specialty care, rural hospitals --
14 consistent with national trends -- are having more
15 difficulty finding physician resources and continue to
16 lose those. We are working with them to help fill
17 those gaps by greater access to Carle physicians in
18 those communities and dedicating resources so that we
19 can coordinate care across the continuum.

20 I will wrap up here briefly.

21 Last year we accepted 4570 transfers from
22 the hospitals in this area that you have noted.
23 25 percent of those patients -- or 1200 patients --
24 came from the two Presence hospitals that you've noted

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1 today. This year we are on pace to receive nearly
2 10 percent more patient transfers, which accounts for
3 approximately 70 beds on any given day.

4 Only 40 percent of Presence's transfers to
5 us relate to trauma -- I'm sorry.

6 Only 14 percent of Presence's transfers
7 relate to trauma patients. What we do find is
8 82 percent of the patients that come into our system
9 actually require a medical/surgical bed in the course
10 of their stay at our facility.

11 Our specialization and collaboration with
12 all hospitals, including the Presence hospitals, is
13 the reason that we are here today. We're committed to
14 being a clinical safety net provider not only for the
15 patients that are in our immediate area but for those
16 that are also low-income patients. In our planning
17 area we are the leading provider of services to
18 uninsured patients and patients enrolled in Medicaid.

19 In 2013 Carle provided \$44 million in
20 charity care to the region's residents. Other
21 comments we made at the last meeting was this includes
22 inpatient services as well as physician and ambulatory
23 outpatient services.

24 We believe we planned this project very

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1 conservatively, as in 2010, when we built our
2 building, we shelled the space as opposed to moving
3 forward with needs at that point in time.

4 We appreciate your thoughts and your
5 considerations on our particular proposal. We are
6 saddened by some of the communication that has come
7 out today, as we have had a very positive partnership
8 in helping to meet the clinical needs of the Presence
9 system over time. In particular I'm not going to
10 address those comments, but we would welcome the
11 opportunity, if you have a question, to answer those.

12 Thank you very much for your time, and we
13 hope that you will support the project, as we want to
14 continue to serve as a strong tertiary care provider
15 to south central and eastern Illinois.

16 Thank you.

17 CHAIRPERSON OLSON: Thank you.

18 Could we please have the gentleman --
19 I believe the CEO -- at the end of the table introduce
20 himself and be sworn in.

21 DR. LEONARD: Dr. Jim Leonard, CEO and
22 president of Carle.

23 CHAIRPERSON OLSON: And can you be sworn
24 in, please?

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1 The COURT REPORTER: Would you raise
2 your right hand.

3 (One witness duly sworn.)

4 THE COURT REPORTER: Thank you.

5 CHAIRPERSON OLSON: Thank you for your
6 comments.

7 Are there questions or comments from Board
8 members?

9 Mr. Sewell.

10 MEMBER SEWELL: Yes, it's on.

11 Do you have any language in your medical
12 staff bylaws that would restrict physicians with
13 admitting privileges at Carle to only admit to Carle?

14 MS. BEEVER: No, we do not. As a matter
15 of fact, our physicians practice and admit at all
16 different facilities.

17 CHAIRPERSON OLSON: So just a --
18 Dr. Burden.

19 MEMBER BURDEN: Thank you -- thank you,
20 Madam Chair.

21 Number one, I missed the meeting here when
22 you guys were here most recently, and I appreciated
23 having an opportunity to review the minutes from that
24 meeting as, obviously, there's always, as you've

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1 heard, public participation presented, opinions which
2 we on the Board have to appreciate and recognize.

3 I personally have interests beyond the scope
4 of what I've heard discussed most loudly and most
5 vociferously. Dr. Eardley's presentation intrigued me
6 as a retired physician who looks forward to what might
7 represent a major step on both the university and the
8 medical school's attempt to develop an engineering
9 program for a combined degree.

10 It may not be something that -- others on
11 the Board -- particularly intrigues them but it does
12 me. I'm not aware of any other medical institution in
13 the country -- if there is one, help me out -- that
14 has and is attempting to do such as we move forward
15 with technology.

16 And old-timers like me -- I'm 81. That's a
17 struggle. Running the television remote is a problem.
18 10-year-old grandsons come to my rescue regularly. So
19 what I'm asking is something that intrigues me.

20 Does this application -- which obviously
21 creates discord amongst competing institutions --
22 we've heard it; we understand it. I've been through
23 that for 50 years. The town and region arguments have
24 been presented. Another institution that's here today

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1 has a similar kind of situation to address.

2 Is this application approval helpful to the
3 point where we should consider it to develop a future
4 program which most others may not care about? I do.

5 Is it appropriate to mention this? Is this
6 trend or interest in developing something which
7 involves the university medical center -- which they
8 may or may not get support from Chicago on --
9 I recognize politics plays a major role in all the
10 items that I'm suggesting -- but I'm asking because
11 I want to hear some thoughts. That's me. I don't
12 want to belabor the point. We're -- everybody seems
13 to want to move along here this morning. There's a
14 lot on the agenda.

15 But that bothers me because I'd like to hear
16 a little bit about it because I, personally, am
17 interested in knowing if this is something that
18 legitimately deserves strong consideration. Is it a
19 remote possibility? Does it demand both outside fund
20 support as well as political support?

21 That's essentially one of the keys for me.

22 DR. LEONARD: Thank you for asking.

23 Okay.

24 Thank -- I'll follow your lead.

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1 Thank you for asking that.

2 The beds that we're asking for today are
3 needed today. But, interestingly, the beds that we're
4 asking for, as has been discussed in my testimony, are
5 part of our strategic plan of going forward and just
6 show how all of this really does come together in what
7 you're asking, to grow the quality level of health
8 care in central Illinois and, hopefully, for the state
9 of Illinois.

10 And so part of this -- no, there is no
11 institution like we are proposing in this new college
12 of medicine that exists anywhere in the world that we
13 are aware of. There are institutions like
14 Massachusetts Institute of Technology and Harvard that
15 cooperate together but don't have it all baked into
16 the medical school that we are trying to create for
17 the future.

18 And so where I'm going with this is, as
19 these plans move ahead, it is a reflection of our
20 vision, our strategic plan -- which is consistent with
21 what you heard 4 years ago and, quite frankly, for the
22 last 15 years -- to raise the bar around technology to
23 be able to deliver health care differently as we move
24 into the future.

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1 about -- to ensure patient access, and, in my mind, a
2 huge piece of access is choice.

3 So I want to be clear that you're stating
4 under oath that your physicians have freedom to admit
5 to any hospital they choose. They can be on staff at
6 another hospital and admit to another hospital? They
7 are not told that they are exclusive to Carle?

8 I need a verbal answer on that. I --

9 DR. LEONARD: That is correct. There
10 are no restrictions.

11 CHAIRPERSON OLSON: Thank you.

12 Questions -- other questions and comments
13 from the Board?

14 (No response.)

15 CHAIRPERSON OLSON: Seeing none, I will
16 call for a roll call vote.

17 MR. AGBODO: Thank you, Madam Chair.

18 The motion was made by Mr. Penn; seconded by
19 Mr. Bradley.

20 Mr. Bradley.

21 MEMBER BRADLEY: When this was discussed
22 before us previously, the majority of those present
23 and voted -- voting -- voted for the project. There
24 was a quirk in our statute that caused you to have to

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1 come back today for a second vote.

2 In the interim you've addressed several
3 objections that were raised. We are now at the point
4 of 19 criteria being reviewed, 1 failing to meet, but
5 a very good justification for how you will meet that
6 within the next two years.

7 Based upon those findings and based on the
8 reputation of Carle, I'm happy to vote yes.

9 MR. AGBODO: Dr. Burden.

10 MEMBER BURDEN: I'm sorry. I didn't
11 appreciate that you -- that you asked me. So
12 I apologize.

13 Well, obviously, I concur with Mr. Bradley's
14 opinion. I would reflect it a little bit more on what
15 I would hope the future brings, despite the fact that
16 I know that the local community -- the medical
17 institutions -- are not looking at the big picture
18 that we have to look at.

19 So I vote yes for the application and look
20 forward to seeing them mature in the direction in
21 which they apparently are headed.

22 Thank you.

23 MR. AGBODO: Senator Demuzio.

24 MEMBER DEMUZIO: Can you hear me?

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1 Okay. I vote --

2 MEMBER BURDEN: We have a short cord.

3 MEMBER DEMUZIO: We have a short cord.

4 I'll do this.

5 I vote yes due to the fact that Carle has an
6 excellent reputation and the fact that you're moving
7 it forward with your innovative ideas and your college
8 of medicine and in your future outlook. And
9 I certainly have -- agree with everything that you --
10 I've heard today that Carle's been doing, and I'm
11 happy to vote yes.

12 MR. AGBODO: Justice Greiman.

13 MEMBER GREIMAN: I'm going to vote yes,
14 primarily -- I'm going to echo Mr. Bradley's
15 observations; however, I would make one other
16 observation, which is important to me in all the files
17 we have, and that is that they have this incredible
18 charitable contribution, almost 5 percent.

19 The average one we see here is 1 percent,
20 2 percent, but they have 4.3 percent, which is a very
21 significant amount of money used. I hope they're not
22 just U of I students in drunken bar fights, but
23 I assume it's not.

24 And, therefore, I do recognize your

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1 charitable contributions and vote aye.

2 MR. AGBODO: Mr. Hayes.

3 VICE CHAIRMAN HAYES: I'm going to vote
4 no because of the State agency report and the --
5 basically -- the conclusion on the service demand.

6 I'd like to say that you are very impressive
7 there with your different programs and working with
8 the University of Illinois, but I would also say that
9 other programs at another hospital certainly work with
10 the students at U of I, as well.

11 So, basically, because of the State agency
12 report on service demand, I'm going to vote no.

13 MR. AGBODO: Mr. Penn.

14 MEMBER PENN: I'm going to vote yes
15 based on the reasons given by Mr. Bradley.

16 MR. AGBODO: Mr. Sewell.

17 MEMBER SEWELL: I'm going to vote yes.

18 I think that this application is largely
19 consistent with the State agency report, and I think
20 that a concern about the reality of rural health care,
21 when it comes to tertiary and specialty care, makes
22 this proposal quite necessary.

23 So I vote yes.

24 MR. AGBODO: Madam Chair Olson.

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1 CHAIRPERSON OLSON: Okay. We're going
2 to go back to public participation. We may not get
3 through all of it. Lunch is scheduled for 12:30.

4 We do have two patients in the audience
5 speaking to 13-076, Holy Cross Hospital. I would like
6 to call those two individuals to the table in addition
7 to Charles Sheets, Charles Holland, and Ron Campbell.

8 Please sign your name and, as soon as you're
9 seated, someone may begin.

10 Again, I will ask you to hold the microphone
11 right next to your mouth. We really want to hear what
12 you have to say.

13 MS. GUTIERREZ: Good morning. My name
14 is Betty Gutierrez. My family has lived in the
15 community and used Holy Cross Hospital for 35 years.

16 I want you to know how important it is to
17 have health services that are nearby. I have a godson
18 who has been treated for mental illness over many
19 years. His mother doesn't drive and she does not
20 speak English.

21 To receive care and visit her son, family
22 members have been required to take half or whole days
23 off of work. This means a loss of pay, and at times
24 of the day public transportation is not an option.

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1 For the sick person and their families,
2 being put in a holding pattern, then placed on a
3 waiting list, then having the added burden to go to a
4 distant place, and then having to have disconnected
5 follow-up care creates a lot of difficulty. These
6 difficulties add to an already painful experience.

7 Honestly, I feel angry and very powerless
8 about living and raising my family in an area that
9 does not have necessary mental health resources.

10 MR. AGBODO: One minute.

11 MS. GUTIERREZ: I am -- have been an
12 increasingly strong advocate for justice in my
13 neighborhood. I wholly and heartedly support
14 Holy Cross Hospital's mission to do what is best for
15 my community.

16 I strongly encourage you to approve
17 inpatient psychiatric care at Holy Cross Hospital.

18 Thank you.

19 CHAIRPERSON OLSON: Thank you.

20 Next, please.

21 MS. RANKINS: My name is LaVerne
22 Rankins.

23 And on Mother's Day of this year, I needed
24 help badly. I was taken to Holy Cross Hospital

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1 emergency room that evening by fire department
2 ambulance. I got there around midnight.

3 At 2:00 the following afternoon, after
4 waiting more than 14 hours, I was transferred by
5 ambulance to another hospital about 16 miles from
6 Holy Cross Hospital and further away from my home.
7 This whole episode was -- of waiting so long in
8 Holy Cross Hospital emergency room while they were
9 trying to find a hospital that would accept me and
10 having to be transferred by ambulance to a different
11 hospital in a community far away from where I live --
12 was so upsetting to me.

13 I know very well that there should be
14 inpatient psychiatric care near my house. There are
15 lots of people who need this type of care that's
16 unable to pay for it, like myself. When they don't
17 have a car or transportation is difficult --

18 MR. AGBODO: One minute.

19 MS. RANKINS: -- having to wait in the
20 emergency room as long as I had to --

21 CHAIRPERSON OLSON: Please conclude your
22 remarks, ma'am.

23 MS. RANKINS: -- and have to be
24 transported as far, it just -- it's not right.

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1 CHAIRPERSON OLSON: Thank you very much,
2 ma'am.

3 Next.

4 MR. HOLLAND: Good morning. I'm Charles
5 Holland, president and CEO of St. Bernard Hospital.

6 Today we remain opposed to the amended
7 project. St. Bernard operates a 40-bed inpatient
8 behavioral health unit that averages a daily census of
9 32 patients or an average of 8 beds available on any
10 given day.

11 Our unit serves Medicaid and uninsured
12 patients with open beds in our unit. And being that
13 we are contracted with the State to treat uninsured
14 individuals with prior inpatient mental health
15 services, we have no reason to turn away patients due
16 to an inability to pay. Any indication to the
17 contrary is confounding to me.

18 The data reported in the Holy Cross study
19 that St. Bernard refused to accept 40 patients for
20 transfer is particularly stunning. After conducting
21 our own internal investigation, we cannot find any
22 records nor any staff accounts to corroborate the
23 data. I have to question whether this study is
24 objective or valid.

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1 Lastly, St. Bernard, along with Sinai Health
2 System and other safety net providers, are meeting in
3 early September to discuss improving the care
4 coordination of behavioral health patients in our
5 communities, something that should have happened from
6 the start.

7 MR. AGBODO: One minute.

8 MR. HOLLAND: We look forward to
9 addressing the mechanisms for transferring patients
10 and to collaborate to improve the delivery of mental
11 health services in our communities.

12 Thank you.

13 CHAIRPERSON OLSON: Thank you.

14 Next, please.

15 MR. CAMPBELL: Good morning. My name is
16 Ronald Campbell. I'm vice president of the
17 coordination of care for St. Bernard Hospital.

18 Thank you for the opportunity to speak to
19 you today on the issue regarding excess capacity of
20 inpatient mental health beds and willingness to serve
21 Holy Cross regardless of whether they have insurance.

22 We oppose Holy Cross' proposal, and our data
23 indicates that it will severely harm our program and
24 limit the services that we can provide to the

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1 community for this important health care need.

2 St. Bernard has a long-standing relationship
3 with Mount Sinai Hospital, partnering with Sinai for
4 patients requiring a higher level of care. Sinai
5 provides us coverage of pulmonary medicine,
6 neonatology, neurosurgery, and orthopedics, among
7 other specialties.

8 If patient transfer had at any time become a
9 concern, we find it surprising that Holy Cross and
10 Sinai Health System have never discussed these issues
11 with us. Our first and only communication that there
12 might be a concern was provided in their letter to
13 this Board earlier this month.

14 Further, the Chicago Department of Public
15 Health, in its mental health services 2013 report,
16 found that the number of mental health-related
17 hospitalizations for clients served at city clinics --

18 MR. AGBODO: One minute.

19 MR. CAMPBELL: -- remains stable since
20 the transition from 12 to 6 clinics as of October.

21 CHAIRPERSON OLSON: Please conclude your
22 remarks.

23 MR. CAMPBELL: Again, we assert that
24 there is no demand for additional AMI beds in the

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1 service area and request the Board reject this
2 application.

3 Thank you for your time.

4 CHAIRPERSON OLSON: Thank you.

5 MR. SHEETS: Hi. I'm Chuck Sheets. I'm
6 here on behalf of the Association of Safety-Net
7 Community Hospitals to oppose the Holy Cross
8 expansion.

9 I just want to remind the Board that
10 Section 2 of the Planning Act spells out the purpose
11 of the Board, and it ends with this statement: "Cost
12 containment and support for safety net services must
13 continue to be central tenets of the certificate of
14 need process."

15 The Act also provides that this Board must
16 take into consideration the priority and needs of the
17 medically underserved areas, giving special
18 consideration to the impact of projects on access to
19 the safety net services. This project will have a
20 significant negative impact on the existing safety net
21 providers in Chicago.

22 The Association of Safety-Net Community
23 Hospitals has 10 members. In Table 1 of the SAR,
24 there are 13 area hospitals within 30 minutes of this

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1 project. None of these hospitals meet the Board's
2 target utilization rate, and 5 of these 13 hospitals
3 are actually safety net providers.

4 Table 8 of the SAR depicts 30 hospitals
5 within 45 minutes of the project, and only 4 of these
6 30 hospitals met the Board's target utilization.

7 I urge you to remember --

8 MR. AGBODO: One minute.

9 MR. SHEETS: -- the Board's statutory
10 charge to protect and support the safety net services.
11 And if approved, this project will hurt those
12 services.

13 Thank you.

14 CHAIRPERSON OLSON: Thank you.

15 Next, we'll have . . .

16 (Discussion off the record.)

17 CHAIRPERSON OLSON: Tim Caveney,
18 Ghian Foreman, Sonia Mehta.

19 MR. CAVENEY: Good morning.

20 CHAIRPERSON OLSON: Please begin.

21 MR. CAVENEY: Thank you.

22 My name is Timothy Caveney. I'm the
23 president and CEO of South Shore Hospital, a safety
24 net hospital serving the southeast side of Chicago for

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1 over 100 years.

2 South Shore Hospital would be directly and
3 negatively affected by the Holy Cross Hospital
4 proposal and we oppose it.

5 There are 210 beds that are currently at
6 37 -- 57 percent access of mental health beds
7 available for inpatient care in the Holy Cross
8 Hospital planning area. This is only a need for
9 134 of these beds, so Holy Cross' proposal to add
10 24 more beds would clearly be significantly more beds
11 than is needed.

12 No unit that is serving -- including ours --
13 is full or even operating at target, so there is
14 simply no need for this project. If the Holy Cross
15 proposal is approved, there will be undue harm caused
16 to safety net providers in the area. As this is a key
17 consideration, one mandated by the State's
18 legislature, the Holy Cross proposal should be
19 rejected.

20 In a recent letter to the Health Facilities
21 and Services Review Board, Holy Cross Hospital
22 indicated they had contacted South Shore Hospital
23 about 40 times in an attempt to place psych patients
24 that had come to their emergency room for treatment.

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1 MR. AGBODO: One minute.

2 MR. CAVENEY: As a practice we maintain
3 a log of all calls for placement of psych patients in
4 our facility.

5 CHAIRPERSON OLSON: Please conclude your
6 remarks.

7 MR. CAVENEY: From March through May of
8 that period, we received only one call from Holy Cross
9 Hospital, which was denied because the patient was too
10 young to be in a unit.

11 CHAIRPERSON OLSON: Please conclude.
12 Thank you.

13 MR. CAVENEY: I thank you for your time
14 and respectfully request the Holy Cross application
15 be denied.

16 CHAIRPERSON OLSON: Thank you.

17 MS. MEHTA: Good afternoon.

18 Good afternoon, ladies and gentlemen. I am
19 Dr. Sonia Mehta, CEO and president of Loretto
20 Hospital, testifying to provide factual information
21 about the position of Loretto Hospital as a provider
22 in the behavioral health care market.

23 Loretto is a safety net hospital on the west
24 side of Chicago serving the city since 1923. We are a

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1 not-for-profit hospital with 70 licensed inpatient
2 behavioral health beds. We continue to have, on an
3 average, 15 to 20 available psych beds and are willing
4 and ready to accept appropriate patients from both
5 Mount Sinai and Holy Cross without their ability to
6 pay.

7 We would not be here testifying today if
8 Mount Sinai and Holy Cross would have entered into
9 discussion with us to collaborate on how to use the
10 existing capacity. We have received only four
11 requests for transfers from behave -- for behavioral
12 health patients from Holy Cross emergency room in the
13 past five months.

14 As we all know, Chicago is overbedded. And
15 with the decrease in inpatient utilization, regionally
16 and nationally, the answer to today's issue is not --

17 MR. AGBODO: One minute.

18 MS. MEHTA: -- more number of beds but
19 it's the desire and efforts to collaborate with other
20 providers in meeting the needs of the behavioral
21 health population.

22 We look forward to working with Holy Cross
23 and Mount Sinai --

24 CHAIRPERSON OLSON: Please conclude.

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1 MS. MEHTA: -- on this important issue.
2 Thank you for your time and consideration.

3 CHAIRPERSON OLSON: Thank you.

4 MR. ROATE: Madam Chair, may I please
5 remind the public participants to sign in.

6 MR. FOREMAN: Good afternoon. My name
7 is Ghian Foreman, and I am the executive director of
8 Greater Southwest Development Corporation or GSDC.

9 GSDC focuses on business services,
10 residential services, senior housing, and community
11 development projects. We currently own and operate
12 over 300 units of senior housing that's located on the
13 southwest side within 1 mile of Holy Cross Hospital.

14 Residents of our facilities with serious
15 mental illnesses and their families often find getting
16 necessary treatment both difficult and frustrating.
17 Our residents typically experience long waits in the
18 Holy Cross Hospital emergency department while a bed
19 for patients requiring inpatient psychiatric services
20 is located, then people often have to be transported
21 many miles to a distant hospital.

22 In a densely populated area like ours, the
23 issues of accessibility both for available beds and
24 transportation are critical.

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1 Throughout the history of GSDC, Holy Cross
2 Hospital has been a critical community resource and a
3 trusted partner. In the past year and a half, we have
4 also seen the commitment to community care and service
5 that Sinai Health System has contributed to expanding
6 the quality --

7 MR. AGBODO: One minute.

8 MR. FOREMAN: -- and range.

9 I strongly urge this Board to approve the
10 inpatient behavioral health unit at Holy Cross
11 Hospital.

12 Thank you.

13 CHAIRPERSON OLSON: Thank you.

14 Next, I'd like to call Loretta Flanagan and
15 Carol Schneider.

16 These will be the last two.

17 (Discussion off the record.)

18 CHAIRPERSON OLSON: Oh, okay. Please
19 come to the table, Carol Schneider and Loretta
20 Flanagan.

21 MR. CERCEO: Madam Chair and members of
22 the Board, my name is Rick Cerceo. I'm chief
23 operating officer at Mercy Hospital and Medical
24 Center. I will be speaking on behalf of Carol

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1 Schneider, our president and CEO, who was unable to
2 attend today's hearing.

3 "Mercy Hospital is opposing this application
4 for the following reasons: First, there is simply no
5 need for additional acute mental illness beds. There
6 are over 300 excess AMI beds within the Applicant's
7 primary referral area, 10 more than when the Board
8 first scheduled the project in April.

9 "Secondly, any problem with patient
10 referrals and placement of AMI patients are not lack
11 of facilities but lack of communication. Just five of
12 our safety net hospitals have excess capacity at
13 five times the patient days Holy Cross is trying to
14 replace. We have already contacted the Applicant and
15 safety net providers to provide a coordinated
16 communication system such that psychiatric referrals
17 are placed on an appropriate and timely basis.

18 "Finally, approval of this application would
19 produce additional hardships on an already fragile
20 safety net hospital network in Chicago.

21 "I respectfully urge the Board to deny this
22 application."

23 Thank you.

24 CHAIRPERSON OLSON: Thank you.

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1 MS. FLANAGAN: Good afternoon. My name
2 is Loretta Flanagan, and I am the executive director
3 of Roseland Community Hospital Foundation.

4 Roseland opened 90 years ago with a mission
5 to provide care to area residents, and despite our
6 challenges, we have maintained this deliberate focus.
7 Each year we expend more than \$20 million on
8 unreimbursed care. Core services we provide include
9 preventive and educational services directed at
10 combating diseases that disproportionately affect our
11 community like asthma, obesity, cancer, diabetes,
12 et cetera, and, of course, mental illness.

13 On July 8th, 2013, our administration, led
14 by our CEO Tim Egan, began restructuring operations to
15 control expenses and to right-size the organization to
16 live within our means and to ensure Roseland continues
17 to serve our communities for years to come. We have
18 emerged from this crisis a stronger organization but
19 are still vulnerable.

20 MR. AGBODO: One minute.

21 MS. FLANAGAN: We oppose the Holy Cross
22 proposal. It was not well thought out from a broader
23 community perspective and jeopardizes many of
24 Chicago's safety net hospitals like Roseland.

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1 Thank you for your time and attention.

2 CHAIRPERSON OLSON: Thank you.

3 I will call now Dennis Ryan and Jennifer
4 MacDonald, and then we will be breaking for lunch.

5 Please proceed.

6 MS. MAC DONALD: Hi. Good afternoon.

7 My name is --

8 CHAIRPERSON OLSON: Right by your mouth.

9 MR. URSO: Put it right up to your
10 mouth.

11 CHAIRPERSON OLSON: Very close.

12 MS. MAC DONALD: Good afternoon. My
13 name is Jennifer MacDonald. I have been an RN for
14 20 years, and for the last 17 years I've worked in the
15 ER at Holy Cross.

16 Our patients needing admission to a
17 psychiatric unit --

18 THE COURT REPORTER: I'm sorry. I can't
19 hear you. Would you please speak up.

20 MS. MAC DONALD: Our patients need
21 admission to a psychiatric unit. Especially our
22 unfunded or charity care patients do not have
23 reasonable access to that service.

24 I am one of the staff members that routinely

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1 tries to find a hospital bed for a psych patient.
2 I was asked a couple months ago to track our
3 difficulties at Mercy and document about 20 patients.

4 I thought it was a waste of my time, but
5 I've known for years which hospitals take the unfunded
6 patients and which don't. I can count on my fingers
7 the number of unfunded psych patients that we have
8 been able -- that we have been able to place anywhere
9 but Madden or Mount Sinai.

10 On average, the unfunded psych patient will
11 sit in the ER for 12 to 16 hours until we can find a
12 bed. If we had a psych unit at Holy Cross, these
13 patients could quickly be admitted.

14 When these patients are waiting for hours on
15 end, they become agitated, become sometimes
16 aggressive, and they and their families don't
17 understand why we can't find placement. We -- we do
18 everything --

19 MR. AGBODO: One minute.

20 MS. MAC DONALD: -- to treat our
21 patients in a dignified, professional, and safe
22 manner.

23 CHAIRPERSON OLSON: Please conclude.

24 MS. MAC DONALD: That's it.

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1 CHAIRPERSON OLSON: Thank you.

2 MR. RYAN: I'm Dennis Ryan. Good
3 morning. I'm here to deliver comments that were
4 our -- on behalf of Dr. Elizabeth Mirkin.

5 "I am board" -- this is from Elizabeth
6 Mirkin.

7 "I am board certified in adult psychiatry,
8 and I've been practicing on the west side of Chicago
9 for over 20 years.

10 "I currently practice at Mount Sinai, and
11 I'm very familiar with the psychiatric patient
12 population seen in Holy Cross' emergency department.
13 Often when patients are transferred from Holy Cross to
14 the inpatient unit at Mount Sinai, I am directly
15 responsible for their care.

16 "I wish to counter one assertion made by the
17 hospitals that are opposing Holy Cross' plan to
18 develop an inpatient psychiatry and to agree with
19 another.

20 "First, I don't understand how any provider
21 can even begin to suggest that greater access to
22 inpatient psychiatric services are not needed. Our
23 unit at Mount Sinai has been operating at functional
24 capacity for years and we have -- often have patients

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1 backed up in our own emergency room. Similarly,
2 Madden state hospital often has a waiting list for
3 admission.

4 "Second, those in opposition to Holy Cross'
5 plan are taking a position that more outpatient
6 program is needed. I couldn't agree more. Both
7 treatment venues are needed.

8 "I have personally worked with Sinai Health
9 System to develop the largest hospital-affiliated
10 outpatient mental health provider network in the
11 metropolitan area. This includes the development" --

12 MR. AGBODO: One minute.

13 MR. RYAN: -- "of an outpatient
14 psychiatry clinic at Holy Cross."

15 CHAIRPERSON OLSON: Please conclude.

16 MR. RYAN: "This is a service the
17 Holy Cross community direly needs, and I urge you to
18 support Holy Cross' plan."

19 Thank you.

20 CHAIRPERSON OLSON: Thank you.

21 We're now going to take a 45-minute lunch
22 break. For those of you keeping score, when we return
23 we will have public participation on Project 14-023,
24 Orland Park ambulatory care facility, and then proceed

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with the rest of our agenda.

It is 12:35, 45 minutes.

(Recess taken, 12:35 p.m. to
1:28 p.m.)

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AFTERNOON SESSION

WEDNESDAY, AUGUST 27, 2014

1:28 P.M.

(Member Penn left the proceedings)

CHAIRPERSON OLSON: We have a quorum.

We're going to start.

Continuing on with public participation, we now have comments on Project 13-023, Orland Park ambulatory care facility.

I will call Daniel McLaughlin, Joseph LaMargo, Paul Grimes, Patricia Gira, and Elaine Simadis.

Remember to hold the microphone close to your mouth, and you have one minute.

Please introduce yourself when you start.

MR. GRIMES: Good afternoon. My name is Paul Grimes. I'm the Village manager for the Village of Orland Park.

Thank you for providing this opportunity today to testify. I'm here to support the University of Chicago Medical Center's application to construct a new outpatient facility in Orland Park. Please note that our mayor, Daniel McLaughlin, has previously submitted a letter supporting this important

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1 development in our community.

2 The population in Orland Park is continuing
3 to see significant growth, and we are located in a
4 region with one of the fastest growing rates in -- or
5 growth rates -- in Illinois.

6 Our population is also aging. The largest
7 generation in US history is retiring, and they will be
8 demanding medical needs closer to their retirements in
9 place. As such, it's very important that we have the
10 necessary facilities to meet the growing demand for
11 care.

12 I have heard from many people in our
13 community who are very appreciative of the care they
14 receive at the university, including lifesaving
15 clinical trials that are not available in other
16 communities, but dread the trip home after receiving
17 that treatment. They and their families say they will
18 appreciate having this advanced care right in our
19 community.

20 We estimate that the project will bring in
21 over 22,000 annual patients and visitors to Orland
22 Park's downtown.

23 MR. AGBODO: One minute.

24 MR. GRIMES: There will be 200

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1 construction jobs and more than 100 permanent jobs.

2 CHAIRPERSON OLSON: Please conclude.

3 MR. GRIMES: Thank you for considering
4 my comments.

5 Thank you.

6 CHAIRPERSON OLSON: Thank you.

7 MR. LA MARGO: Good afternoon. My name
8 is Joe LaMargo. I am the board president of Orlando
9 School District 135.

10 I support the University of Chicago's
11 application to construct a new outpatient facility in
12 Orland Park. Many patients in our -- in our school
13 community have approached me since the announcement of
14 this project. Parents and children are being treated
15 for cancer and other serious problems.

16 Currently, to get the kind of care available
17 exclusively at an academic medical center, families
18 have to take an entire day off, arrange for child
19 care, and drive to Chicago in heavy traffic before
20 their treatments can even begin. On top of an already
21 serious treatment, like radiation and chemotherapy,
22 the process of going into Chicago is exhausting.

23 The new facility will be a great relief for
24 families in our community, who will be able to receive

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1 treatment closer to home and stay connected to their
2 schools.

3 The outpatient facility will be beneficial
4 for our school community. The ability to partner with
5 a local hospital will also benefit our students and
6 staff as we implement the next-generation science
7 standards to develop critical thinkers for tomorrow.

8 MR. AGBODO: One minute.

9 MR. LA MARGO: We expect that the
10 patient center will be a hub of activity for
11 Orland Park.

12 Thank you.

13 CHAIRPERSON OLSON: Thank you.

14 MS. SIMADIS: My name is Elaine Simadis.
15 And having been faced with two cancer diagnoses,
16 knowing that treatment would be received at one of the
17 most prestigious cancer research facilities in the
18 world made me feel safe.

19 When leukemia struck my 7-year-old, my
20 comfort was the late Dr. Knox, the ruling physician
21 and a child cancer research specialist. The leukemia
22 protocol was terrific, but the stress and anxiety of
23 waking a child who was already compromised at the
24 crack of dawn to make it down to Hyde Park for chemo

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1 and spinal tap was overwhelming.

2 A facility closer to home would help reduce
3 the stress and anxiety faced by the family and the
4 patient. Waiting 20 to 30 minutes for a car after
5 chemo and then facing an hour or hour-and-a-half ride
6 home with a 7-year-old is brutal.

7 The University of Chicago's physicians and
8 staff saved my child's life by taking a cutting-edge
9 approach to his treatment, his body, and his mind.
10 A facility in the suburbs would offer these brilliant
11 physicians to more families who face the unthinkable
12 while significantly reducing the outside stress of
13 commuting.

14 After firsthand experience with the U of C's
15 cutting-edge approach to fighting cancer, I knew there
16 was no other place I wanted to be when my diagnosis of
17 breast cancer came three years after my son's. My
18 only regret is the commute, the parking difficulties,
19 and the overcrowding that my son and I faced.

20 MR. AGBODO: One minute.

21 MS. SIMADIS: I want to be where the
22 innovators and thinkers are, and the facility in
23 Orland Park would offer that to the families out in
24 the southwest suburbs.

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1 CHAIRPERSON OLSON: Thank you.

2 Next, I'd like call Joe Kaplan, Alexander
3 Goldenberg, Talisa Hardin, Adourthus H. McDowell,
4 Veronica Morris Moore, and Victoria Musica -- Mugica.

5 Sorry about the pronunciation.

6 Please go ahead.

7 MR. KAPLAN: My name is Joe Kaplan. I'm
8 a student at the University of Chicago and a member of
9 the group Students for Health Equity. I'm here to
10 oppose Project 14-023.

11 There are currently no adult trauma
12 facilities on the south side of Chicago, which puts
13 hundreds of thousands of people in danger every
14 single day. Despite this grave situation, Sharon
15 O'Keefe and the University of Chicago Leadership
16 decided to use \$67 million to build a facility for
17 high-profit services in Orland Park, which is 20 miles
18 away from their main campus. The hospital's mission
19 is to generate huge profits at whatever cost, even if
20 that means refusing to treat poor people or stripping
21 patients from other hospitals.

22 Orland Park is already served by
23 nine facilities that offer services similar to those
24 UCMC wants in its new hospital, but CEO Sharon O'Keefe

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1 and the leadership of UCMC don't care what is best for
2 our community, whether it's Orland Park or the south
3 side of Chicago. In fact, they repeatedly ignore
4 their own community health needs assessment, which
5 identified access to trauma care as a critical issue
6 to their south-side patient base.

7 As a student at the University of Chicago,
8 I find the behavior to shamelessly pursue profit
9 institutionally immoral. I think it is wrong for an
10 institution that I am a part of to make deliberate
11 choices to allow pain and suffering to continue --

12 MR. AGBODO: One minute.

13 MR. KAPLAN: -- on Chicago's south side
14 when they have the power to stop it.

15 I urge the Board to consider the
16 consequences of allowing the UCMC to treat for-pay
17 services and to --

18 CHAIRPERSON OLSON: Please conclude.

19 MR. KAPLAN: -- pursue profits ahead of
20 the needs of the south side.

21 Thanks.

22 CHAIRPERSON OLSON: Thank you.

23 MR. GOLDENBERG: My name is Alex
24 Goldenberg, speaking on behalf of the Trauma Care

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1 Coalition in opposition of the University of Chicago
2 Orland Park project.

3 This Board's responsibility is to protect
4 the people of Illinois from rising health care costs
5 and duplication of services. The proposal by Sharon
6 O'Keefe, president of the University of Chicago
7 Hospital, duplicates services, contributes to the rise
8 in health care costs, and stands in the way of
9 providing health care for those most in need.

10 Ms. O'Keefe's proposal is about making
11 money. Orland Park already has nine other facilities
12 to provide the services Ms. O'Keefe is proposing. Her
13 plan will strip patients from those facilities,
14 duplicate services, and result in higher costs, and
15 it's your mandate to stop this from happening.

16 While Ms. O'Keefe draws up a \$60 million
17 plan to duplicate services and increase profits, her
18 hospital sits in the middle of a gun violence epidemic
19 plaguing the south side of Chicago. And instead of
20 treating those dying at her doors, she turns her back
21 on them.

22 As the recent Ebola outbreak has plagued
23 Liberia and neighboring countries, I can't help but
24 compare it to the gun violence epidemic on the south

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1 side. It's unthinkable to imagine a world-class
2 hospital in Liberia refusing to treat people with
3 Ebola. Well, that's exactly what Ms. O'Keefe and the
4 University of Chicago Hospital is doing.

5 This Orland Park project represents the
6 wrong priorities. It's wrong for Orland Park, wrong
7 for the south side, and wrong for the people of
8 Illinois.

9 MR. AGBODO: One minute.

10 MR. GOLDENBERG: I urge you to vote no.

11 CHAIRPERSON OLSON: Thank you.

12 Next.

13 MS. HARDIN: My name is Talisa Hardin,
14 and I'm a registered nurse.

15 I work at the University of Chicago Medical
16 Center, and I serve as the chief nurse representative
17 with National Nurses United. We oppose Project 14-023
18 for a number of reasons.

19 First, UCMC received an enormous tax break
20 as a nonprofit facility and, in return, is supposed to
21 provide care for indigent patients within the
22 surrounding community. The surrounding community has
23 for years been asking UCMC to reestablish an adult
24 Level I trauma center on the south side. People die

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1 because driving distance and time in heavy traffic
2 delays access to lifesaving care.

3 Meanwhile, despite having high property
4 levels surrounding the facility and a fourth home
5 health business located within striking distance of
6 the property, UCMC provides less than 1.4 percent of
7 its net revenue in direct provision of care to the
8 poor in the community it purports to serve.

9 Rather, UCMC has chosen to locate a
10 \$66 million outpatient facility to a community
11 25 miles distant, in an affluent village with more
12 than 11 other facilities nearby that provide the same
13 or similar services.

14 The local oncologists opposed to this
15 project cite a plethora of available services, as does
16 this Board's own staff.

17 MR. AGBODO: One minute.

18 MS. HARDIN: So I ask, what is the value
19 of life? We respectfully ask you to deny this
20 particular need for Project No. 14-023.

21 CHAIRPERSON OLSON: Thank you.

22 Next.

23 MR. MC DOWELL: Good afternoon. My name
24 is Adourthus McDowell. I'm with the Kenwood Oakland

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1 Community Organization and a member of the Trauma Care
2 Coalition.

3 I am before you today to encourage you to
4 sanction the University of Chicago Medical Center as a
5 result of their unwillingness to respond to the urgent
6 need for a trauma center in their home community of
7 Woodlawn on Chicago's south side.

8 While the University of Chicago Medical
9 Center has submitted an application based on need, we
10 urge you to recognize the difference between a dire
11 need and a desire. We cannot take issue with the
12 Orland Park community having access to quality health
13 care. We do have to take issue with the fact that,
14 for years, a public education campaign has taken place
15 and highlights the urgent need for a trauma center in
16 the southeast region of Chicago where one does not
17 currently exist.

18 So I call on you to act in the best
19 interests of the people of Illinois and the south side
20 of Chicago. We need a Level I trauma center now.

21 Thank you.

22 CHAIRPERSON OLSON: Thank you.

23 REVEREND HARPER-JONES: Good afternoon.

24 I'm Reverend Alice Harper-Jones. I'm an ordained

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1 minister in the United Church of Christ, and I serve
2 as associate pastor at Kenwood United Church of
3 Christ, which is in the heart of the Hyde Park and
4 Kenwood area.

5 At any time of the day that we are in
6 service, someone might experience a need for trauma
7 care, and they would be denied because the University
8 of Chicago has closed up their doors and they have
9 denied entrance because of -- they do not want the
10 trauma center there.

11 So we're asking you not to open -- allow
12 them to have a facility in Orland Park because to do
13 this is immoral and it's a violation of human rights
14 that they do not have a trauma center on the south
15 side in Chicago but extend to the south suburbs and as
16 far as Indiana.

17 We need the trauma center. We need the
18 trauma center. And that is why we are here, to say we
19 are in support of those who have spoken, in support of
20 the young people at the university, and in support of
21 the members of the community, the young people who
22 started this whole movement, because we believe that
23 God is not satisfied when we, God's people, are not
24 being served.

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1 So the university is very rich in resources
2 academically and --

3 MR. AGBODO: One minute.

4 REVEREND HARPER-JONES: -- and, also,
5 economically.

6 CHAIRPERSON OLSON: Please conclude your
7 remarks.

8 REVEREND HARPER-JONES: They're very,
9 very poor in sensitivity to the needs of the
10 community.

11 Thank you.

12 CHAIRPERSON OLSON: Ma'am, were you
13 speaking on behalf of the Fearless Leading by the
14 Youth?

15 REVEREND HARPER-JONES: Yes. I'm
16 speaking in place of Veronica Morris Moore. She
17 couldn't make it.

18 CHAIRPERSON OLSON: Thank you. Okay.
19 Victoria.

20 MS. MUGICA: Hello. Can you hear me?

21 My name is Victoria Mugica. I'm a master's
22 prepared nurse who has worked at the University of
23 Chicago for more than 20 years now. And I'm here --

24 CHAIRPERSON OLSON: Closer.

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1 MS. MUGICA: Closer?

2 CHAIRPERSON OLSON: Is it on?

3 MS. MUGICA: It says it's on.

4 MEMBER BURDEN: Just put it closer.

5 MS. MUGICA: I don't know how much
6 closer. I'll try again.

7 My name is Victoria Mugica. I'm a master's
8 prepared nurse who has been working at the University
9 of Chicago for more than 20 years now.

10 And I'm here in support of the ambulatory
11 care building in Orlando Park. In my current role as
12 a nurse coordinator in our call center, I coordinate
13 follow-up appointments in the heart and vascular
14 center and am in a unique position to hear patients'
15 concern about access to care.

16 For patients in the south and southwest
17 suburbs, the most commonly identified concern is the
18 distance and travel time required for services. This
19 is the greatest concern to the patients who require
20 frequent follow-up for services that are not available
21 in the community, such as advanced heart failure
22 management, ventricular assist devices and
23 transplants, as well as patients who have undergone
24 complex endovascular and fluoroscopic procedures that

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1 CHAIRPERSON OLSON: We are now moving on
2 to applications subject to initial review. The first
3 project is H-01, 13-076, Holy Cross Hospital in
4 Chicago.

5 Would the Applicant please come to the
6 table.

7 May I have a motion to approve Project 13 --
8 first of all, I need to mention for the record that
9 Member Penn will not be in attendance at this
10 afternoon's session.

11 May I have a motion to approve
12 Project 13-076, Holy Cross Hospital, to establish a
13 24-bed AMI service?

14 May I have a motion?

15 MEMBER DEMUZIO: Motion.

16 MEMBER BURDEN: Second.

17 CHAIRPERSON OLSON: It has been moved
18 and seconded.

19 May we have the State Board staff report?

20 MR. ROATE: Thank you, Madam Chair.

21 The Applicants are Sinai Health System and
22 Holy Cross Hospital, and they're proposing the
23 establishment of a 24-bed acute mental illness
24 category of service at their hospital in Chicago.

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1 Cost of the project, \$4.4 million, and
2 anticipated project completion date of December 15th,
3 2015.

4 State Board staff notes that a public
5 hearing was held regarding the project on March 4,
6 2014; a second public hearing was held on this project
7 on July 31st, 2014.

8 The Applicants -- it's also noted the
9 Applicants deferred this project at the April 2014
10 meeting and subsequently modified the project on
11 May 15th. The modification consisted of a reduction
12 in the number of AMI beds from 50 to 24 beds and a
13 reduction in the cost from \$8.4 million to the cost of
14 \$4.4 million noted.

15 There are two negative findings, one in the
16 area of planning area need due to a calculated excess
17 of AMI beds in the planning area, and unnecessary
18 duplication -- potential unnecessary duplication or
19 maldistribution of services based on the fact that
20 there are hospitals in the area that are operating
21 beneath the prescribed capacity.

22 Thank you, Madam Chair.

23 CHAIRPERSON OLSON: Would the
24 individuals at the table please introduce yourselves

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1 and be sworn in.

2 The COURT REPORTER: Would you raise
3 your right hands, please.

4 (Seven witnesses duly sworn.)

5 THE COURT REPORTER: Thank you. Please
6 introduce yourselves.

7 SISTER WENDT: I'm Sister Immacula
8 Wendt, W-e-n-d-t.

9 MS. TEITELBAUM: Karen Teitelbaum,
10 T-e-i-t-e-l-b-a-u-m.

11 MR. AXEL: Jack Axel, A-x-e-l, Axel &
12 Associates.

13 DR. AHLUWALIA: Yogi Ahluwalia,
14 A-h-l-u-w-a-l-i-a.

15 MS. RANALLI: Clare Ranalli,
16 R-a-n-a-l-l-i.

17 MR. BROWN: Mark Brown, B-r-o-w-n.

18 MR. CARNEY: Joseph Carney, C-a-r-n-e-y.

19 CHAIRPERSON OLSON: Go ahead.

20 SISTER WENDT: Good afternoon. I'm
21 Sister Immacula Wendt.

22 It was during my tenure as general superior
23 of the Sisters of St. Casimir, sponsors of Holy Cross
24 Hospital, that a decision was made to transition

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1 Holy Cross Hospital since it had become more and more
2 difficult to remain a stand-alone hospital. It's been
3 a year and a half now since Holy Cross became part of
4 the Sinai Health System and the Sinai family.

5 When I testified before you, I shared the
6 key important criteria that the Sisters sought in
7 identifying Sinai Health System as our partner:
8 Commitment to high-quality care to all who come to us
9 in their need, Holy Cross would remain a Catholic
10 hospital, and the ability and willingness to provide a
11 viable and stable future.

12 Today I am able to report that Sinai Health
13 System has and continues to deliver solid and strong
14 commitment to Holy Cross Hospital and keeping these
15 key criteria.

16 Due to this new partnership, the southwest-
17 side community is better served today. New physicians
18 and caregivers have been infused into the community.
19 Since the transition, a nearly \$8 million electronic
20 medical record has been installed at Holy Cross
21 Hospital. A community health assessment resulted in
22 the development of a number of new programs, including
23 an outpatient mental health clinic.

24 The Sisters have not gone away. We remain

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1 as religious sponsors of Holy Cross Hospital and
2 oversee the continued Catholic identity. Our
3 emergence as part of and commitment to the southwest
4 side continues.

5 Among the programs that the Sisters have
6 been actively involved in, on a hands-on basis, for
7 the past 20 years has been our community food pantry.
8 Through that special ministry of service, we have been
9 working closely with many of the individuals now
10 benefiting from the mental health services that are
11 provided by Sinai Health System, and many of these
12 same neighbors will directly benefit from the proposed
13 inpatient program.

14 This is a gap in access that we, Holy Cross
15 Hospital, SWOP -- the Southwest Organizing Project --
16 and other neighborhood services identified years ago
17 and one that was confirmed by Sinai's community
18 assessment that Holy Cross, as a stand-alone hospital,
19 did not have the resources to address.

20 With those introductory comments, I urge you
21 to support this project, and I turn the microphone
22 over to Ms. Teitelbaum.

23 MS. TEITELBAUM: Thank you, Sister
24 Immacula.

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1 I'm going to ask Joe and Mark to speak
2 first, and then I will speak.

3 MR. BROWN: My name is Mark Brown. I'm
4 a registered nurse at Holy Cross Hospital. I've been
5 working in their ER for almost seven years.

6 I participated in the hospital's tracking
7 system of transferring psychiatric patients. I was
8 personally involved in attempting to arrange 15 to
9 20 of these transfers during the study period.

10 Other hospitals who are saying that they'll
11 take our patients is totally inconsistent with my
12 personal experience. I can tell you that the detailed
13 transfer study which was completed in the last
14 few months documents the same unacceptable situation
15 with these patients that we have experienced in
16 Holy Cross for years.

17 When attempting to transfer a psychiatric
18 patient who needs admission, I will call another
19 hospital. I'll be asked to fax them information,
20 including the patient's funding source.

21 When given a reason for turning down that
22 admission, it's typically "We do not have any beds
23 available," "We don't have any unfunded beds
24 available," "We can't take any unfunded patients,"

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1 "We don't take patients with a history of violence";
2 colloquially, "The patient doesn't meet our" --
3 quote/unquote -- "admission criteria."

4 We have the most difficulty when we attempt
5 to transfer an unfunded or charity care patient, a
6 patient enrolled in a Medicaid program, or a patient
7 with a history of violence. Unfortunately, most of
8 our psychiatric patients in our ER fall into one of
9 these categories.

10 From the perspective of someone who
11 interacts with these psychiatric patients on a daily
12 basis, there is no doubt in my mind that inpatient
13 psychiatric is needed at Holy Cross.

14 MR. CARNEY: Hello. My name is
15 Joe Carney, and I'm the director of emergency services
16 at Holy Cross Hospital.

17 I was asked by Sinai's leadership to
18 coordinate a three-month study of Holy Cross
19 ER patients that needed transfer to another
20 psychiatric facility. The purpose of the study was to
21 report difficulties and/or delays in the transfer of
22 these patients.

23 The findings of the study absolutely confirm
24 what the ER staff already knew. We knew that

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1 significant access issues face the psychiatric
2 patients who come into our emergency department, and
3 we knew which hospitals will typically take our
4 patients and which won't. The findings of our study
5 were provided to you on August 5th.

6 During the three-month study, 179 patients
7 were transferred to psychiatric hospitals or
8 psychiatric units from our emergency department. Of
9 the four hospitals that I identified are most
10 vehemently in opposition to Holy Cross opening an
11 inpatient psychiatric service, our detailed study
12 showed the following: These opposition hospitals were
13 called 147 times during the three-month study period
14 and accepted six patients. These are patients in need
15 of inpatient care, and my experience tells me they do
16 not have reasonable access to care, regardless of
17 whether there are empty beds at other hospitals
18 or not.

19 Thank you.

20 MS. TEITELBAUM: Thank you.

21 My name is Karen Teitelbaum. I'm the
22 president and CEO of Sinai Health System.

23 By any definition, Sinai Health System is a
24 safety net provider and one of the largest providers

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1 of health care for low-income patients in Illinois.
2 Our service areas include some of the most
3 economically disadvantaged neighborhoods in Chicago.
4 Our payments reflect that, with 60 percent Medicaid,
5 15 percent uninsured, and only 5 percent of our
6 patients with private insurance.

7 As a system, we provided over \$46 million in
8 charity care just last year. And despite the
9 challenges that we face, we are -- our quality scores
10 are high and we offer high-quality and safe care.

11 And at our core -- we've been around for
12 about a hundred years, and at our core our belief has
13 always been that there should not be two levels of
14 care, one for our economically disadvantaged
15 communities and one for more prosperous. We think
16 that that's just unacceptable, and that includes
17 whether or not there are factors of access for our
18 communities, payer status, or severity of illness.

19 When Holy Cross Hospital joined our system,
20 we completed a community needs assessment in the
21 neighborhood surrounding the hospital. We identified
22 a critical void -- no surprise to any of us -- in
23 accessibility to mental health services for those
24 patients and those people living right in the

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1 Holy Cross community.

2 This led to our opening of an outpatient
3 mental health clinic at Holy Cross Hospital that now
4 operates five days a week. While Sinai's provision of
5 a system of outpatient mental health programming is
6 robust and is about the largest in the state with over
7 79,000 visits a year, our inpatient capacity remains
8 very limited.

9 We have just 28 AMI beds at Mount Sinai
10 Hospital, and that unit has been operating in a
11 functional capacity for a number of years. Virtually
12 all the patients who are admitted to our Mount Sinai
13 inpatient unit come through the ER from one of our
14 two hospitals. And despite what we've heard, we are
15 challenged every single day to find a bed for those
16 psychiatric patients in need of admission.

17 This situation is exacerbated at -- by -- at
18 Holy Cross by the hospital's lack of a psychiatric
19 unit. Our revised proposal for just 24 beds would
20 allow us to address the needs of our ER patients.

21 To be perfectly clear here, we're talking
22 about access to needed inpatient mental health
23 services for the uninsured and for Medicaid --

24 CHAIRPERSON OLSON: Switch mics. That

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1 one's cutting in and out.

2 MS. TEITELBAUM: Last year -- let me
3 start again.

4 To be perfectly clear, we're talking about
5 access to needed inpatient mental health services --
6 is that better?

7 CHAIRPERSON OLSON: Uh-huh.

8 MS. TEITELBAUM: Can you hear me?
9 -- for the uninsured and for the Medicaid
10 recipients.

11 Last year 42 percent of the mental health
12 patients seen in the Holy Cross ER were characterized
13 as charity care, and approximately 75 percent of those
14 patients transferred out were either totally unfunded
15 or were Medicaid recipients.

16 I'm sure that the hospitals opposing this
17 project admit many of the uninsured and Medicaid
18 recipients that show up in their own ERs. That's not
19 what we're talking about. We're talking about
20 reasonable access for those patients who are seen in
21 the ER of Holy Cross and who are in need of admission
22 to a psychiatric bed.

23 These patients should not have to wait for
24 the hours and the days in our ER to only then be

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1 loaded into another ambulance, be taken to another
2 hospital, where they are once again processed and then
3 finally being taken to an inpatient bed.

4 The assertion that Holy Cross Hospital's not
5 calling the other hospitals in the area really begs
6 the question. If those hospitals will accept our
7 patients readily, why are so many patients waiting in
8 our ER for hours if not days?

9 We've heard opposing hospitals say that they
10 would admit Holy Cross patients but that we never call
11 them. Because this was inconsistent with our
12 experience, we did the three-month study referenced to
13 document the difficulties that our patients have in
14 accessing inpatient acute mental health services and
15 the challenges that the Holy Cross ER staff face when
16 trying to find a needed bed.

17 The findings of our study as described,
18 provided to you in our August 5th filing, didn't
19 surprise our Holy Cross Hospital staff. It only
20 confirmed what we know.

21 Joe has gone through the data on that.
22 Again, one of the hospitals opposing the project was
23 called 27 times, accepting just four patients.
24 Another hospital was called 45 times, accepting just

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1 one. Another was called 40 times over that
2 three-month period and accepted no patients. In
3 total, the hospitals that have spoken in opposition to
4 this project were called 188 times and accepted a
5 total of only 15 patients.

6 During that three-month period, 17 percent
7 of the patients waited in the ER for 12 or more hours
8 after an order for a transfer had been written while
9 the staff tried to find a bed. 47 percent waited at
10 least eight hours, and that is just unacceptable.
11 These are the most frail patients. These are patients
12 in crisis.

13 The pie chart that you see here identifies
14 the payer mix for this group of patients.

15 The pie chart. Have you got that?

16 As you can see, approximately 75 percent of
17 the patients are unfunded patients or Medicaid
18 recipients.

19 The State agency report identifies a number
20 of hospitals within a half hour of Holy Cross, and
21 that's a MapQuest calculation based on typical drive
22 times. Those drive time estimates just don't mean
23 much, however, to the financially challenged patients
24 that we treat, as you heard in very, very vivid detail

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1 this morning from our community members who have had
2 to face using public transportation to get the care
3 that they need while in crisis.

4 Driving time doesn't matter if you have to
5 rely on public transportation to visit a loved one in
6 the hospital or to obtain follow-up care to an
7 inpatient stay. Again, it's an issue of reasonable
8 accessibility.

9 For example, if you need to get to Mercy
10 Hospital from Holy Cross Hospital, the drive time,
11 according to MapQuest, is 20 minutes. But with public
12 transportation you're taking two buses and a train
13 over an hour long one way every time you must go for
14 discharge care.

15 If you live near Holy Cross and rely on
16 public transportation, you do not have reasonable
17 accessibility to an inpatient mental health care unit,
18 and you certainly don't have it on a timely basis.

19 With the outpatient mental health capability
20 already on Holy Cross' campus, patients admitted to
21 the proposed Holy Cross unit can receive follow-up
22 care right here in our community.

23 Our ER staff patients -- know these patients
24 the best, and the staff estimates that about

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1 60 percent of the patients rely on CTA and are without
2 public transportation -- without private
3 transportation.

4 In closing, our staff report had only
5 two negative findings, both resulting from empty beds
6 at other hospitals. I believe we've already discussed
7 and demonstrated that those beds are, in a majority of
8 instances, not reasonably accessible to the patient
9 population that we are asking your permission to
10 serve.

11 Section 1110.730.c.5 is entitled "Service
12 Accessibility." The subsection "Service Restriction"
13 states "The Applicant shall document that at least one
14 of the following factors exists in the planning area,"
15 and one of those factors is "access limitations due to
16 payer status of patients, including but not limited to
17 individuals with health care coverage through
18 Medicare, Medicaid, managed care, or charity care."

19 We firmly believe that our study confirms
20 that access limitations exist and particularly for
21 those unfunded patients that we want to serve. In
22 fact, one of the closer AMI providers limits
23 admissions to children and adolescents, one limits
24 admissions to geriatrics, and some others place long

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1 limitations on patients they'll accept. For example,
2 if the patient has been recently incarcerated, is in a
3 late trimester -- past the first trimester of
4 pregnancy, has a known history of violence, there is a
5 reluctance or a flat-out refusal to accept those
6 patients.

7 Mount Sinai Hospital's unit operates with no
8 exclusionary criteria, and I can commit to you that
9 Holy Cross' unit will do the same.

10 We are interested in collaboration. We
11 always have been. In fact, I have reached out. When
12 I took the CEO position this past July 1st, one of the
13 first calls that I made was to Mr. Holland at
14 St. Bernard's, who -- we've been good partners on a
15 number of services over the years.

16 I asked Mr. Holland -- I went to visit him
17 and asked him to convene a meeting not just of the
18 safety nets but also of other potential partners to
19 look at the much bigger issue of mental health
20 services that are needed and how we can help and
21 collaborate as a network across the system. That does
22 not in any way obviate the need for a small, inpatient
23 unit to address the needs of the Holy Cross Hospital
24 community.

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1 In closing, I'd like to express our
2 appreciation to the Board and to the many community
3 organizations, agencies, elected officials who know
4 this patient population well and who have expressed
5 support for this project, including community agencies
6 such as Access Community Health Network, Metropolitan
7 Family Services, National Alliance on Mental Health,
8 Community Behavioral Health Association, the Greater
9 Southwest Development Corporation, House Speaker
10 Madigan, Cook County Board President Toni Preckwinkle,
11 Cook County Sheriff Thomas Dart, and, most
12 importantly, I thank the area residents and the
13 churches who have voiced their support.

14 So, again, let me thank you, members of the
15 Board. And on behalf of those residents seeking
16 access to services right in their community, I urge
17 you to support this application.

18 Thank you.

19 CHAIRPERSON OLSON: Questions and
20 comments from Board members?

21 Doctor.

22 MEMBER BURDEN: It's clear to me, as a
23 member of this Board for some time --

24 CHAIRPERSON OLSON: You need to turn

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1 that on.

2 MEMBER BURDEN: Well, I can talk loud.

3 Is this better? That's better. I can hear
4 it, too.

5 It's clear to me, from the years that I've
6 been on this Board, that on occasion this -- our State
7 Board staff does a super job and really has a rather
8 damning Table 1, page 2, demonstrating that no
9 hospital facility for AMI beds or planning area meet
10 the State standard, which makes it harder for me to
11 understand this when I hear what you, under oath, have
12 just projected.

13 I, as a retired physician, see this as a
14 core issue for potential explosion of both trauma and
15 acute mental illness in an area that's clearly
16 underserved. I'm bothered.

17 I believe that I have to listen carefully to
18 your statements and Sister's comments. Sinai, to me,
19 has been a savior out there. All my Russian-Jewish
20 pals all identify this to me when I see them socially
21 and I hear you report what you do.

22 I'm just concerned because it does bother me
23 that you feel that, with this acute mental illness
24 service available to you and a full-time psychiatrist

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1 present, that you will, in time, be able to serve your
2 community. Will it remain a State standard unmet? Or
3 will it remain a State standard met? Which might help
4 me in terms of my attitude towards this application.

5 I am concerned -- I believe that we have to
6 separate, on occasion, what data is in front of me
7 with the Applicant's clear, under-oath expression and
8 documentation.

9 That's terrible to hear the experience of an
10 ER and frustrating as hell. How do you keep good
11 people when they meet this on an ongoing, constant
12 basis? As a retired doctor, I recognize how that
13 influences staff, and your good employees will go
14 elsewhere if they can't get this solved eventually in
15 time.

16 So that's my feeling on it. I don't have
17 any question that you've presented what you think is a
18 logical way to proceed. My worry a bit is will you be
19 able to satisfy the State Board needs for your unit
20 if, indeed, it does get approved today.

21 MS. TEITELBAUM: Thank you. I really
22 appreciate those comments.

23 And, yes, I believe that we will -- I'm very
24 sure that we will be able to meet the State Board

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1 requirements. We right now, of course, with our unit
2 at Mount Sinai Hospital, are very, very busy. We, in
3 fact, operate at functional capacity, and we, too,
4 refer patients out of our own unit.

5 But we see immediately patients -- and you
6 heard very vividly from the patients this morning that
7 patients are waiting. They could be seen immediately
8 without waiting for transfer. And, of course,
9 occasionally we have patients who simply will --
10 they're in crisis and they simply will not wait in the
11 ED to be seen.

12 So if we have the small unit at Holy Cross
13 Hospital, we will be able to -- and I think very
14 easily -- fill the unit with appropriate patients who
15 are not being accepted elsewhere.

16 CHAIRPERSON OLSON: Other questions or
17 comments?

18 (No response.)

19 CHAIRPERSON OLSON: I have a question.
20 Matt, does DHS have a stance in support
21 or -- of this project?

22 MEMBER HAMMOUDEH: Thank you --
23 thank you, Madam Chair.

24 Yes. Yes, they do. And consistent with the

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1 testimony, DHS does support the establishment of this
2 category of service. As the testimony indicated, the
3 existence of beds in the proximity doesn't necessarily
4 translate into access.

5 And Holy Cross Hospital serves as a safety
6 net in that community, and we would like to see them
7 get this category of service granted.

8 CHAIRPERSON OLSON: Thank you.

9 I'm -- I'm really confused. I mean, I think
10 your study is very compelling, and I sit there and
11 listen to you say -- you gentlemen at the end of the
12 table -- that you were the ones involved in this
13 study, so it's kind of mind-boggling to me that
14 somebody would come -- and I know they were not under
15 oath but -- absolutely contradict your survey.

16 I mean, I understand that you're under oath
17 and you're saying that it's real, so I find it
18 disturbing that somebody would just contradict it
19 based on -- you know, I do appreciate the fact that
20 the other health systems want to reach out and improve
21 communication. And I think, despite how the vote
22 goes, I would encourage that still to happen because
23 24 beds is not 54 beds.

24 I know that you -- but on the other hand,

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1 I think it seems sort of late in the game to reach out
2 for a meeting that's after the application has been
3 submitted. It's too bad that that didn't happen
4 before. Just one opinion.

5 Other questions or comments?

6 Clare, did you having something?

7 MS. RANALLI: Yes.

8 I don't know if it's --

9 CHAIRPERSON OLSON: That one's not
10 working.

11 MS. RANALLI: You -- we spoke -- I just
12 want to also let the Board know -- because we also
13 were surprised -- and probably believe it's just a
14 lack of communication, possibly, between like staff
15 and leadership at certain hospitals.

16 But I can assure you that on various
17 levels -- and I went to Mr. Carney and Jack, working
18 closely with the data and my reviewing it page by
19 page -- and we even backed out some situations where
20 it was unclear. We were very, very careful with the
21 data and believe it's very reliable.

22 And we also want to mention, in the way of
23 collaboration, absolutely collaboration is good. And
24 I know that St. Bernard's and Mount Sinai have

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1 collaborated together for years as well as some of the
2 other safety net hospitals.

3 But the majority of these patients are
4 brought to the ED by first responders, and all the
5 collaboration in the world won't change that because
6 the first responders have rules, and they have to
7 bring them to Holy Cross. So no matter what we do,
8 those patients will be triaged, treated for any
9 medical condition, and then have to wait until we can
10 find a bed. The best of collaboration won't change
11 that for these patients.

12 And that's why the unit size was reduced, to
13 directly reduce the ED patients, and that also was
14 done in a collaborative effort to address the other
15 hospitals' statements and concerns.

16 CHAIRPERSON OLSON: Thank you.

17 Other questions or comments from Board
18 members?

19 VICE CHAIRMAN HAYES: Madam Chair.

20 CHAIRPERSON OLSON: Yes.

21 VICE CHAIRMAN HAYES: You know, with
22 your study here, I thought it was kind of
23 interesting -- is that -- this is Table 7 on page 19.

24 You do have it for Mount Sinai Hospital,

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1 which is part of your system there. And, you know,
2 these patients are difficult to place because
3 I understand the occupancy at Mount Sinai is pretty
4 high.

5 But, still, only -- less than 20 percent
6 were actually -- that were asked -- or, basically,
7 inquiries from Holy Cross to Mount Sinai, only
8 20 percent were accepted in your study; is that
9 correct?

10 MR. AXEL: Yes, that is correct.

11 And what we're running into at Mount
12 Sinai --

13 MR. URSO: Can you use the microphone?
14 Use the microphone.

15 CHAIRPERSON OLSON: The one that works,
16 please.

17 MR. AXEL: What we're running into is,
18 at Holy Cross, the first call is to Mount Sinai to see
19 if they have a bed.

20 And when Ms. Teitelbaum says we are
21 operating at functional capacity, what that means is
22 most of the rooms on the 26-bed psych unit at Mount
23 Sinai are low -- are semiprivate rooms.

24 This is a tough patient population that

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1 we're handling, and often a bed in one of the rooms
2 needs to be blocked off. That's why Mount Sinai
3 developed their -- their occupancy rate is in the low
4 80s, can't always accept patients, and, in fact,
5 last year Mount Sinai had to transfer out 416 of their
6 own patients.

7 So often, when the Holy Cross ER calls
8 Mount Sinai, there isn't a bed available. And on --
9 quite frankly, on most of the patients that were sent
10 over there, the answer from Mount Sinai is "We don't
11 have a bed available. If you can't find a bed
12 someplace else, we may have something available later
13 today or tomorrow," and the patient ends up waiting
14 while they're looking for another bed at another
15 hospital and ultimately gets transferred over to
16 Mount Sinai.

17 Did that answer your question, Mr. Hayes?

18 VICE CHAIRMAN HAYES: Yes. Yes.

19 MR. AXEL: Thank you.

20 VICE CHAIRMAN HAYES: I have another
21 one, and this is just for my own information, that --
22 and it's probably somewhere in the documentation, and
23 it's been in the letters.

24 You have -- how are patients that are at the

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1 Cook County Jail and -- how are they handled for their
2 needs for acute mental illness?

3 Could you just -- let me -- are you aware of
4 that?

5 DR. AHLUWALIA: Yeah. I'm one of the
6 treating attending physicians, psychiatrists, at
7 Mount Sinai for the last 34 years.

8 We do get a lot of patients who are
9 incarcerated. If the charges are pressed against them
10 and they're under arrest, we treat them but then
11 they're transferred to Cook County Jail Hospital.

12 If there are no charges pressed, then we do
13 admit them in our inpatient area.

14 VICE CHAIRMAN HAYES: Okay. So if there
15 are charges against them, they're eventually
16 transferred to Cook County Hospital --

17 DR. AHLUWALIA: Yeah.

18 VICE CHAIRMAN HAYES: -- for their
19 treatment there?

20 DR. AHLUWALIA: Yeah. But we do follow
21 those patients when they are discharged from
22 Cook County Jail Hospital for outpatient care at
23 Mount Sinai.

24 VICE CHAIRMAN HAYES: Okay. And how do

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1 you -- you have proper security, then, for this --
2 these -- your unit is very -- your unit is segregated;
3 is that correct? From the general patient population.

4 MR. AXEL: It's a locked unit on a floor
5 separate from the med/surg units.

6 VICE CHAIRMAN HAYES: And the proposed
7 unit at Holy Cross will be similar?

8 MR. AXEL: Correct.

9 VICE CHAIRMAN HAYES: And it will be on,
10 what, the third floor there?

11 MR. AXEL: Fifth? Or . . . fifth
12 floor -- the fifth or sixth floor, yes.

13 VICE CHAIRMAN HAYES: Okay. It's the
14 higher one, the fifth or sixth. Okay.

15 MR. AXEL: Yes.

16 VICE CHAIRMAN HAYES: All right.

17 Thank you very much.

18 DR. AHLUWALIA: Thank you.

19 CHAIRPERSON OLSON: Other questions or
20 comments from the Board?

21 (No response.)

22 CHAIRPERSON OLSON: Seeing none, I'll
23 call for a roll call vote, please.

24 MR. AGBODO: Thank you, Madam Chair.

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1 The motion was made by Senator Demuzio and
2 seconded by Dr. Burden.

3 Mr. Bradley.

4 MEMBER BRADLEY: I'm going to take some
5 time on this issue.

6 The Board staff report says there's a
7 calculated excess of 76 AMI beds in the planning area,
8 30 hospitals within 45 minutes provide this service
9 and, of the 30, 4 are operating at the Board's
10 85 percent target occupancy. I think that's a
11 significant finding.

12 Second significant finding: There are
13 13 hospitals within 30 minutes providing these
14 services. Of the 13 hospitals, none are operating at
15 the target occupancy. It also appears that the
16 proposed project will impact other underutilized
17 hospitals in the planning area.

18 Based on that alone, I think it would be
19 difficult to support this proposal.

20 But beyond that, the proponents at the desk
21 said one thing that I take great exception to. They
22 lump Medicaid clients in with unfunded. Medicaid
23 clients are not unfunded. The State of Illinois is
24 the payer for those.

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1 We shouldn't be thinking, "Oh, these
2 wonderful people are taking these unfunded patients."
3 They are not. They fight very hard in the legislature
4 for that funding, and Mount Sinai does extremely well
5 in that funding stream.

6 As I've observed Mount Sinai over the years
7 under the late Ruth Rothstein and under Ben Greenspan,
8 this institution was a leader among the safety net
9 hospitals. It was a strong voice for safety net
10 hospitals. It was collaborative with the safety net
11 hospitals, yet, today, we have a proposal before us
12 that is opposed by the other safety net hospitals who
13 have indicated strongly that they think this will hurt
14 them.

15 So the choice is -- do we favor one hospital
16 over a host of hospitals out there in the community
17 serving the patients that we're supposed to be the
18 most concerned about? I think, under Mr. Channing,
19 the focus of Mount Sinai Hospital changed, and I think
20 it's unfortunate that they come in as opponents of the
21 safety net hospitals rather than working
22 collaboratively with them as proponents of a service
23 that is badly needed.

24 If the utilization between the hospitals is

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1 not correct, the answer is not for Sinai to pick up
2 more beds, I believe. The answer is to improve
3 communications among the hospitals.

4 For that reason, I cannot support this
5 issue. I want to be shown as present and nonvoting.

6 MR. AGBODO: Dr. Burden.

7 MEMBER BURDEN: I appreciate
8 Mr. Bradley's comments. I never served -- recognizing
9 what he did and the individuals he mentioned, I knew
10 them, but I also know, practicing medicine in the city
11 of Chicago -- Children's Memorial Hospital,
12 et cetera -- for 40 years, Medicaid reimbursement
13 drastically changed from the time I left Johns Hopkins
14 and attended at Children's Memorial Hospital. I saw a
15 great reimbursement rate sort of disappear. Any
16 number of my colleagues 15 years younger than I --
17 I've been retired 13 years -- are not going to take
18 Medicaid patients, despite the ACA, and I understand
19 that.

20 I'm looking at a social problem that bothers
21 me a lot. I recognize what Mr. Bradley has said and
22 I respect his opinion. He's certainly more
23 knowledgeable than I regarding the features of
24 Springfield.

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1 As a practitioner and a guy at the other
2 end, other than Sister Rosemary at Misericordia,
3 I have never been around any institution that had,
4 quote/unquote, "success" in lobbying unless they hired
5 lobbyists on a full-time basis.

6 I recognize what you've said -- you're under
7 oath -- and I personally feel strongly about the
8 social commitment if no other. This community and,
9 indeed, maybe all these institutions that claim to be
10 serving the community need to have a collaborative
11 communication network built in time.

12 But we're talking about a problem right now
13 that appears to me to be only solvable by not
14 recognizing some of the features of this State report,
15 so I'm going to vote yes.

16 MR. AGBODO: Senator Demuzio.

17 MEMBER DEMUZIO: Yes.

18 In looking at the State report where it does
19 say that there's the unnecessary duplication and the
20 bed need in the two findings that the State -- our
21 State report has indicated, I normally -- I take that
22 into serious account; however, I believe that you have
23 addressed those two issues here in your testimony
24 today and thank you for doing that because I think

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1 that has cleared it up.

2 There have been some contradictory
3 statements made here today in terms of communication
4 or number -- and I know the graph showed this and
5 whatever, and I think I would recommend that you go
6 back and try to make sure that there's some better
7 communications that some of your neighboring hospitals
8 have indicated that there's not been. Okay?

9 However, having said that, I'm going to go
10 ahead and vote yes, and I -- I wish you the best of
11 luck in your endeavors.

12 MR. AGBODO: Justice Greiman.

13 MEMBER GREIMAN: I recognize the
14 reservations that the previous speakers have made, and
15 I share some of the feelings, but it's clear that
16 there's a concern about actually taking people that
17 are recommended -- that are -- when they call and they
18 say "We have somebody here" and they say, "Sorry,
19 we're filled up."

20 And that's too many times so I'm voting yes.

21 MR. AGBODO: Mr. Hayes.

22 VICE CHAIRMAN HAYES: You know,
23 I certainly appreciate the comments that have been
24 made. And I think, with your going back on this

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1 project from the last meeting and your changing the
2 number of beds and really about cutting them in about
3 half there, I think that you've addressed the needs of
4 the community and some of the limitations of excess
5 that you all experience -- that you've mentioned as
6 well as the opposition.

7 So I think it's -- I think you do an
8 excellent job, and I think that this unit at
9 Holy Cross will improve excess for the community, and
10 I think we have to look beyond some of this -- areas
11 of the -- concerns in the State agency report.

12 And I'm going to vote yes in this case.

13 MR. AGBODO: Mr. Sewell.

14 MEMBER SEWELL: I vote no.

15 I think there's a disconnect between what's
16 happening in the acute mental illness system and this
17 as a solution. Adding beds is not the solution when
18 there is sufficient capacity in the system. This
19 project is a result of probably really good
20 institutional planning, but there's no systemwide
21 planning because there is capacity here.

22 And so I think that all of the players, all
23 of the providers that do acute mental illness
24 services, need to go back to the drawing board and

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1 figure out what they're going to do because they've
2 got the physical capacity. The physical capacity is
3 not the solution for this problem.

4 So I vote no.

5 MR. AGBODO: Madam Chair Olson.

6 CHAIRPERSON OLSON: Lots of good
7 comments here. I think the theme going through is
8 there needs to be communication.

9 But I'm going to have to agree with
10 Dr. Burden that the need is immediate; the need is
11 now. Based on your three-month study, something has
12 to be done. Patients cannot sit in an emergency room
13 for hours and hours on end.

14 I could not have supported this project in
15 April. I appreciate the fact you went back to the
16 drawing board and reduced the number of beds. I also
17 feel like the other health systems had an opportunity
18 between April and -- it's now the very end of
19 August -- to reach out and to communicate. I hope the
20 communication will take place.

21 I am going to vote yes on the project with
22 the hope that communication still takes place.

23 MR. AGBODO: I note down 5 yes, 1 no,
24 1 present, 2 absent.

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CHAIRPERSON OLSON: The motion passes.
Good Luck.

MR. AXEL: Thank you.

MS. TEITELBAUM: Thank you.

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1 CHAIRPERSON OLSON: Okay. Next, we have
2 Project H-02, 14-021, Northwest Community Hospital in
3 Arlington Heights.

4 While the Applicants come to the table, may
5 I have a motion to approve Project 14-021, Northwest
6 Community Hospital, to establish a 17-bed
7 comprehensive physical rehabilitation unit?

8 May I have a motion?

9 Focus, people.

10 May I have a motion?

11 MS. AVERY: Motion?

12 MEMBER GREIMAN: Second.

13 VICE CHAIRMAN HAYES: So moved.

14 MEMBER SEWELL: I'll second. I'll
15 second.

16 CHAIRPERSON OLSON: Mr. Hayes moved;
17 Mr. Sewell seconded.

18 MR. AGBODO: Thank you.

19 CHAIRPERSON OLSON: Would the Applicants
20 please introduce yourselves and be sworn in.

21 The COURT REPORTER: Would you raise
22 your right hands, please.

23 (Four witnesses duly sworn.)

24 THE COURT REPORTER: Thank you. If

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1 you'd just please introduce yourselves and print your
2 name.

3 MS. NAGY: Kimberly Nagy, N-a-g-y.

4 MR. SCOGNA: Stephen Scogna, S-c-o-g-n-a.

5 MR. WEBER: Ralph Weber, W-e-b-e-r.

6 MR. BUXTON: Brad Buxton, B-u-x-t-o-n.

7 CHAIRPERSON OLSON: George, may I have
8 the State Board staff report, please.

9 MR. ROATE: Thank you, Madam Chair.

10 The Applicant is proposing to establish a
11 17-bed comprehensive physical rehabilitation unit on
12 the campus of Northwest Community Hospital at
13 Arlington Heights.

14 The cost of the project is \$3 million, and
15 the anticipated project completion date is
16 September 1st, 2015.

17 A public hearing was held on this project on
18 July 22nd, 2014, with 22 individuals presenting
19 oral/written testimony in support and 2 presenting
20 opposition to the project.

21 Board staff found negative findings -- a
22 negative finding in the area of planning area need due
23 to the fact that there's a calculated excess of
24 75 comprehensive rehabilitation beds in the service

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1 area.

2 Thank you, Madam Chair.

3 CHAIRPERSON OLSON: Thank you, George.

4 Comments for the Board?

5 MR. SCOGNA: Thank you.

6 First of all, I would like to thank the
7 Board members for the opportunity to present our
8 project.

9 As stated earlier, I'm Steve Scogna. I'm
10 the president and CEO of Northwest Community. And
11 what I'd like to do is -- while this project has
12 substantially been in compliance, I would like to talk
13 first about the negative finding in the State agency
14 report and make a few other comments as relates to the
15 support of our proposed project.

16 The only negative finding relates to the
17 calculated excess of 75 comprehensive physical
18 rehabilitation beds in suburban Cook County and
19 DuPage County.

20 While this is a calculated excess in the
21 State's planning area, our permit application makes
22 the case that this is not so in our service area. In
23 fact, the State agency report acknowledges that the
24 project does not create any maldistribution or

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1 duplication.

2 Within the 30-minute travel time of
3 Northwest Community Hospital, the ratio of rehab beds
4 to population is 0.09. That is significantly lower
5 than the rehab bed ratios for the entire state of
6 Illinois and for HSA 7. The rehab beds population
7 ratio within the 30-minute travel time geography is
8 37 percent less than the HSA average for the rehab
9 beds and 32 percent less than the ratio for the entire
10 state of Illinois.

11 Similarly, the experience use rate which is
12 used in the State's formula for determining bed need
13 is significantly lower, for the 30-minute travel time
14 geography, than the use rates for the State and, also,
15 for the HSA.

16 As a result, the State report finds that
17 there is no maldistribution of beds and that there is
18 no duplication of services as a result of this
19 project. We believe this is one of the most
20 significant sections of the permit application and use
21 the State's own review metrics to make the case for
22 this finding.

23 In addition, most of our primary and
24 secondary service areas in northern Cook and Lake

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1 County lie north of I-90 and west of I-294 and I-94.
2 There are only two inpatient rehab programs in this
3 vast area between Arlington Heights and the Wisconsin
4 border, one at Centegra in McHenry and one at
5 Vista West in Waukegan. Together they have a total of
6 only 47 inpatient hospital beds, and, in fact,
7 Centegra has written a letter of support for this
8 project. These numbers are quantitative evidence of a
9 lack of sufficient beds in our immediate service area.

10 Additional evidence is apparent in the
11 ongoing difficulty that patients encounter in
12 obtaining inpatient rehab care locally after their
13 acute care stays.

14 As our staff and our patients have reported
15 at the public hearing in July, there were three main
16 access issues: First, some patients who need rehab
17 are not admitted to these units either due to a lack
18 of bed availability at those hospitals or due to their
19 self-pay status or their limited insurance coverage.
20 These patients receive rehab services at nursing homes
21 or at home, but they miss the three-hours-per-day
22 regimen at an inpatient rehab unit that are needed for
23 the optimal recovery.

24 The second area for most patients who are

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1 able to get admitted to a hospital rehab unit, there
2 is a delay of between one and four days due to waiting
3 for a bed to become available at the rehab hospital or
4 due to insurance verifications. These delays add cost
5 to both the patient as well as to the system while the
6 patient grows weaker from their rehab -- waiting for
7 their rehab services.

8 The third area was when a patient is
9 transferred to another hospital for rehabilitation.
10 They lose connection with the physicians and staff who
11 provided their acute care. For these patients,
12 especially those who require rehospitalization for
13 these conditions and receive treatment at the
14 hospitals with the rehab unit, there is no continuity
15 of care. Patients and families tell us frequently
16 that they want to be cared for where the staff is
17 known. That's how patients and their families define
18 the continuity of care.

19 Northwest Community Hospital has selected
20 RehabCare as its partner in setting up and operating
21 this proposed unit. As discussed earlier, RehabCare
22 is the largest provider of therapy services in the US
23 and is delivering care to over 518,000 patients. This
24 includes over 43,000 patients in inpatient rehab

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1 units. In Illinois RehabCare has over 29 years of
2 experience and has operated seven rehab units.

3 It's important to note that the State agency
4 reports finds that this 17-bed project will have no
5 negative impact on area hospitals with rehabilitation
6 units. This conclusion is supported by the analysis
7 of NCH patients matching rehabilitation impairment
8 codes or RIC codes.

9 Of the NCH patients last year who matched
10 the rehabilitation impairment code and qualified for
11 rehab care, only 3.5 percent actually converted to
12 inpatient rehab in an acute care hospital. To be
13 clear, there were many more patients that met the
14 clinical criteria; however, they did not get in due to
15 access issues. Based on RehabCare's national
16 experience and the volume of patients in different
17 relevant clinical categories at NCH, this should have
18 been about 13 percent.

19 In order to be conservative, we assume only
20 10 percent of the patients matching a code will
21 convert to inpatient rehab. That means enough
22 patients to fill both the 17-bed unit at an 85 percent
23 occupancy and to refer over 230 patients, which is
24 actually slightly higher than what our history has

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1 been in terms of referring patients.

2 As a result, there should be no negative
3 impact on other providers in this planning area. The
4 State report concludes that the project is in
5 conformance with the criteria related to the impact on
6 other area hospitals.

7 Northwest Community Hospital is a large,
8 independent provider of health care services. It's
9 not a member of one of the emerging systems. Our
10 emergency room is the largest in the area, with almost
11 71,000 visits, of which 13,600 are trauma. Our
12 emergency room volume rivals that of academic medical
13 centers and is a source of a significant volume of
14 trauma cases and brain injury patients who often need
15 inpatient rehab. Our large stroke program is also a
16 significant source of patients who need inpatient
17 rehab.

18 We have recently recruited a new medical
19 director and chief neurosurgeon to oversee that
20 program in which growing -- which is growing and
21 contributes to the need for rehab.

22 Moreover, over 80 percent of the patients
23 that NCH refers for inpatient hospital rehab care are
24 over the age of 65, a population that is expected to

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1 increase by 16 percent in six years, by 2020. We
2 firmly believe this project meets a growing community
3 need without having any negative impacts on our area
4 providers.

5 Having a rehabilitation unit within the
6 hospital further supports our ability to prepare for
7 the Affordable Care Act. In the interest of time,
8 I'll explain that later if you would like me to do so.
9 I can only say that I'm very proud of NCH and our
10 commitment to provide the best care to our community.

11 For now I'd like to thank the State staff
12 for their work on the project and thank you for the
13 opportunity to make this statement.

14 CHAIRPERSON OLSON: Thank you.

15 Questions or comments from Board members?

16 Dr. Burden.

17 MEMBER BURDEN: Who's your new female
18 neurosurgeon/CEO?

19 MR. SCOGNA: I'm sorry?

20 MEMBER BURDEN: Is your new neurosurgeon
21 female?

22 MR. SCOGNA: No. It's a male, Dr. --

23 MEMBER BURDEN: Oh, I thought you said
24 female.

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1 MR. SCOGNA: Oh, no, no.

2 Dr. Shaun O' Leary.

3 MEMBER BURDEN: Uh-oh -- no, I'm
4 teasing. I'm teasing.

5 MR. SCOGNA: I know I'm relieved.

6 CHAIRPERSON OLSON: Other questions or
7 comments from the Board members?

8 (No response.)

9 CHAIRPERSON OLSON: There being none,
10 I'll call for a roll call vote.

11 MR. AGBODO: Thank you, Madam Chair.

12 The motion was made by Mr. Hayes; seconded
13 by Mr. Sewell.

14 Mr. Bradley.

15 MEMBER BRADLEY: I think they've made a
16 very good case for this, there are no exceptions in
17 the State agency report, and I vote yes.

18 MR. AGBODO: Dr. Burden.

19 MEMBER BURDEN: I know Mr. Bradley
20 attended the meeting held out there in July. And
21 I anticipate that his observation weighs on me since
22 he has attended, seems to be very careful with figures
23 and numbers.

24 So based on Mr. Bradley's assessment, I vote

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1 yes, as well.

2 MR. AGBODO: Senator Demuzio.

3 MEMBER DEMUZIO: Yes. I vote yes for
4 the reasons stated previously.

5 MR. AGBODO: Judge Greiman.

6 MEMBER GREIMAN: Mr. Bradley is often
7 correct. I follow his guidance, too, and vote yes.

8 MR. AGBODO: Mr. Hayes.

9 VICE CHAIRMAN HAYES: Well, I'm going to
10 vote no in this case because there is a calculated
11 excess of 75 comprehensive rehabilitation beds in the
12 HSA 7 comprehensive planning area.

13 And, also, you know, sometimes -- there's
14 always a -- you know, sometimes we're looking at a --
15 this is kind of a certificate of need program, and
16 many times people come in front of us with a
17 certificate of want.

18 So, you know, I -- so my -- in this case,
19 I'm going to vote no.

20 MR. AGBODO: Mr. Sewell.

21 MEMBER SEWELL: I vote no because of
22 the 1110.630 planning area need excess of
23 comprehensive rehab beds in HSA 7.

24 MR. AGBODO: Madam Chair Olson.

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1 CHAIRPERSON OLSON: There is a
2 calculated excess of 75 beds in the HSA; however, the
3 State Board staff report reports no negative impact to
4 area hospitals. And I'm alarmed at the lack of
5 continuity of care for these patients in this area,
6 and I believe the access is very poor based on a
7 0.09 rehab bed-per-population ratio.

8 So I vote yes.

9 MR. AGBODO: I have 5 voting for yes,
10 2 for no, and 2 absent.

11 CHAIRPERSON OLSON: The motion passes.
12 Congratulations.

13 MR. SCOGNA: Thank you.

14 MS. NAGY: Thank you.

15 MR. WEBER: Thank you.

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ASBURY COURT NURSING & REHABILITATION

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1 CHAIRPERSON OLSON: Next, we have
2 Project H-03, 14-22, Asbury Court Nursing &
3 Rehabilitation in Des Plaines.

4 May I have a motion? While the Applicant's
5 coming to the table, may I have a motion to approve
6 Project 14-022, Asbury Court Nursing & Rehabilitation,
7 to establish a 71-bed skilled nursing unit?

8 VICE CHAIRMAN HAYES: So moved.

9 MEMBER SEWELL: Second.

10 CHAIRPERSON OLSON: Please introduce
11 yourself for the court reporter and be sworn in.

12 The COURT REPORTER: Would you raise
13 your right hands, please.

14 (Seven witnesses duly sworn.)

15 THE COURT REPORTER: Thank you. Please
16 introduce yourselves.

17 MR. KNIERY: Good afternoon. My name is
18 John Kniery, K-n-i-e-r-y, CON consultant.

19 MR. SHEETS: Chuck Sheets, S-h-e-e-t-s,
20 Polsi nell i .

21 MS. COOPER: Anne Cooper with
22 Polsi nell i .

23 MR. TALBOT: Bob Talbot, administrator
24 nurse and nursing consultant for Asbury.

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1 MR. CHASE: Joseph Chase, COO of Asbury.

2 MR. ZAHTZ: Michael Zahtz, Z-a-h-t-z,
3 Asbury CFO.

4 THE COURT REPORTER: I'm sorry. Your
5 title?

6 MR. ZAHTZ: CFO. Asbury CFO.

7 THE COURT REPORTER: Thank you.

8 MR. FOLEY: Charles Foley, F-o-l-e-y.

9 CHAIRPERSON OLSON: Okay. George, State
10 Board staff report, please.

11 MR. ROATE: Thank you, Madam Chair.

12 The Applicants propose to construct and
13 operate a 71-bed long-term care unit on the campus of
14 an existing retirement community.

15 The anticipated project cost is
16 \$7.2 million, and the anticipated completion date is
17 July 31st, 2016.

18 Board staff notes that on January 27th,
19 2009, the Applicants received a permit on a similar
20 project, Project 08-064, to establish a 75-bed skilled
21 nursing unit on the campus of this existing retirement
22 community. The only difference was this permit was
23 awarded under the Continuum of Care Retirement
24 Community variance, the CCRC variance. At the

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1 time this -- that the project -- the cost of this
2 project, the Project 08-064, was \$4.2 million.

3 The Applicants are essentially applying
4 to establish this 71-bed skilled nursing unit in
5 exclusion of the CCRC variance.

6 Thank you, Madam Chair.

7 CHAIRPERSON OLSON: Okay. Comments for
8 the Board?

9 MR. SHEETS: Good afternoon.

10 In the interest of time, I'll try to go
11 quickly but . . . Asbury Court is an existing
12 retirement community with 225 independent-living units
13 and 150 supportive-living units that predominantly
14 serve low-income individuals and Medicaid residents.

15 Still not working?

16 MS. AVERY: It is but you have to hold
17 it very close.

18 CHAIRPERSON OLSON: You have to hold it
19 very close.

20 MR. SHEETS: Okay. I hope we're all
21 well today.

22 CHAIRPERSON OLSON: Yeah, no kidding.

23 MR. SHEETS: The supportive-living
24 program is a unique program in the state of Illinois.

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1 It's a Medicaid waiver program, but I thought I'd take
2 a minute and describe it to you.

3 It is a program where -- essentially, it's
4 Medicaid assisted-living services, so it's a step down
5 from nursing home care but it's something more than
6 independent living in an apartment. There are
7 medication reminders, et cetera, such -- like there
8 are in assisted-living programs for the private-pay
9 individuals.

10 And in this particular community, we have
11 225 apartments for the elderly, and then we have
12 150 supportive-living units. And the unique part
13 about the supportive-living program is that it takes
14 light-care nursing home patients and it pays -- the
15 State pays 60 percent of the Medicaid nursing home
16 rate and, thus, saves money taking care of Medicaid
17 residents in a setting that's more independent. They
18 have a private room; they have a microwave and a
19 refrigerator and their own private bathroom, and they
20 can lock their door at night.

21 So it's a unique setting that I thought
22 I would describe to you so that you might understand
23 where we're going.

24 Originally when this program was filed --

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1 when this project was filed -- it was going to be
2 under the CCRC variance, but, unfortunately, the -- as
3 you can see from the State agency report, the costs of
4 the project have increased dramatically. They've gone
5 up 71 percent.

6 So let me just briefly describe the reasons
7 we're here. The establishment of a skilled nursing
8 facility on the campus will provide residents at
9 Asbury Court's independent- and supportive-living
10 units the full continuum of care and allow them to age
11 in place.

12 We are basically here for three reasons:
13 The construction costs are projected to exceed the
14 approved permit that we had before by 71 percent, and
15 we want to reduce the size of the unit from 75 beds to
16 71 beds, and we also want to remove the variance. We
17 want to be able to have a Medicare therapy unit in the
18 building that we can admit from the community.

19 The Applicants are a small provider and have
20 limited experience in the construction of skilled
21 nursing facilities. Asbury Gardens, a nursing and
22 rehab center which was licensed in November of 2013,
23 was their first skilled nursing facility in over
24 30 years. It was that application that served as a

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1 model for the application that's in front of you now.

2 While the Applicants have learned from their
3 prior experience with Asbury Gardens, that -- the
4 project began during the depth of the recession --
5 that project began in the depth of the recession when
6 the construction industry was depressed and
7 construction costs were significantly lower than they
8 are today.

9 The increased project costs are due, in
10 part, to a savings realized -- to savings realized on
11 the other project that are no longer available in the
12 construction industry for this project. So, in other
13 words, they've just gone up tremendously.

14 In addition, there were changes in the
15 design of the building. The original project had
16 shared bathrooms between two rooms. And as you
17 probably heard from me many times before, that's sort
18 of an old design that doesn't work anymore in the
19 skilled nursing industry. The new project, of course,
20 has private rooms -- not private rooms but private
21 bathrooms for each resident room.

22 Additionally, we're seeking to reduce the
23 size from 71 beds from -- from 75 beds to 71 beds.
24 Bear in mind that the 75 beds previously approved by

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1 the Board are currently in the need inventory, so this
2 change, if you should actually decide to approve this
3 project, will actually increase the need in the HSA,
4 and the HSA right now has a need of 446 beds in
5 this HSA.

6 The reduction in beds -- you're probably
7 wondering why we're reducing it. It's a redesign
8 because we needed a little more extra room for the
9 bathrooms, and we just don't have enough physical
10 space to accommodate those extra rooms.

11 Finally, I'd like to reiterate that this
12 project is predominantly serving low-income and
13 Medicaid populations. That's how it's designed.
14 That's how the community is designed, and we want to
15 allow a full continuum of care to allow them to age in
16 place.

17 So I thank you for your time, and we're here
18 to answer any questions you might have.

19 CHAIRPERSON OLSON: Questions or
20 comments from Board members?

21 Mr. Sewell.

22 MEMBER SEWELL: Oh, that's right.
23 Sorry.

24 Yes. I wanted to ask about the -- some of

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1 these financial ratios. You appear to be off a bit in
2 relation to the State standard on things like cushion
3 ratio and projected debt service coverage.

4 Could you speak to some of these?

5 MR. KNIERY: I'll initially start out
6 addressing those and then -- thanks for the question.

7 What the ratios point out is representative
8 of the difference between a typical nursing provider
9 and that of the Applicant.

10 The difference is twofold: First, the
11 Applicant is a small mom-and-pop provider who have
12 traditionally used available cash to reinvest into its
13 business. As a result, you have the ratios that
14 you do.

15 This point is more -- the second point is
16 more important: The Applicant has served and is
17 choosing to serve primarily the Medicaid and
18 low-income population.

19 The resulting ratios are not representative,
20 also, of the entire picture when a single business is
21 divided and looked at by its parts. The ratios for a
22 single business model as found on page 26 of the
23 CON application are more in line with the State's
24 norms.

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1 MEMBER SEWELL: And a follow-up on
2 that -- not a follow-up but another -- under the
3 availability-of-funds criteria, has anything changed
4 with respect to this commitment letter from the bank
5 that is participating in the financing?

6 MR. SHEETS: Well, Member Sewell, let me
7 just add one thing to the prior question.

8 In that supportive-living facility
9 I described, 84 percent of the beds are Medicaid, so
10 that gives you an idea of the model we're serving,
11 which is reflected in the financials, actually.

12 But with regard to the commitment, I'd like
13 to ask Mr. Zahtz to respond to that. He's one of the
14 owners.

15 MR. ZAHTZ: We expect --

16 THE COURT REPORTER: I can't hear a
17 word. Sorry.

18 MR. ZAHTZ: We expect to have a
19 commitment within the next 90 days.

20 MR. SHEETS: And as you can see, they've
21 expended a lot of funds already, so they're invested
22 in the project.

23 CHAIRPERSON OLSON: Other questions or
24 comments?

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1 (No response.)

2 CHAIRPERSON OLSON: I'm not really clear
3 on why you're -- based on the numbers that you started
4 out with of who's already living there, why do you
5 want to remove the variance?

6 MR. SHEETS: Well, that's a good
7 question, too.

8 The variance -- because the financial model
9 has changed with the increased costs, we need to have
10 a Medicare population that we're taking care of in
11 order to offset the Medicaid small margins or no
12 margins, depending on how you look at it.

13 So the design is for a Medicare unit, a
14 therapy unit, to admit from the outside, and the goal
15 is actually sort of a reverse CCRC goal, where
16 somebody might come in who has a fall in the community
17 who's elderly. And then they come in for therapy, and
18 eventually they might get put in the independent
19 living or in the actual supportive-living program as
20 opposed to being transferred out to a nursing home
21 somewhere else. So that's one goal.

22 And the other goal, of course -- well, the
23 problem we have is that the rules don't allow us to go
24 partially under the variance and partially not under

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1 the variance. So we're not anticipating any more than
2 35 beds at any point in time being used for outside of
3 the community, but at this point our projections
4 require that in order to get the Medicare patients in
5 the building.

6 MR. CHASE: Can I add something?

7 Having operated in a supportive-living
8 setting for the last 12 years, practically on a daily
9 basis we get a phone call from local rehab centers
10 looking to -- you'll have, like Charles had said,
11 people that -- from the community -- go into rehab for
12 whatever reason. And after going through rehab, it's
13 determined that they can't go back home, but yet
14 they're not necessarily in need of a full skilled
15 nursing facility.

16 And that's where, as a supportive-
17 living unit -- which we do accept people that are on
18 Medicaid -- we have a lot of referrals from people in
19 other rehab centers that cannot go home anymore.

20 And as he stated, there is the concept of
21 the reverse CCRC, of which people -- if we can admit
22 people from the community, they do their rehabbing,
23 and then we're able to keep them on -- in our
24 supportive-living environment -- on Medicaid. That

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1 would -- that's also part of the big picture as to why
2 we would like to change that variance.

3 Also, to add to what Charles said earlier,
4 in addition to redesigning a lot of aspects to the
5 facility, we've actually added showers into every
6 single room. And that also answers as to why we're
7 doing it -- we're requesting the reduction from
8 75 beds to 71 beds, because now we will have private
9 showers for every resident, whereas before they were
10 sharing.

11 I just wanted to point that out, as well.

12 CHAIRPERSON OLSON: Go ahead.

13 I -- just to -- one more question and then
14 I'll . . . so -- I'm troubled by the 71 percent
15 increase.

16 I do understand that construction was way
17 down previously and now it's coming back up again,
18 but -- so I -- and I also understand you've changed
19 the design of some of the bathrooms, and I know
20 bathrooms are expensive.

21 But do you have any idea of how much of that
22 71 percent increase is attributable to the change in
23 the design and how much is construction? Because
24 I just don't think construction costs have gone up

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1 71 percent.

2 MR. SHEETS: Well, we can talk about the
3 actual numbers. You know, the costs per square foot
4 are actually still within the Board's norm, \$228 per
5 square foot.

6 But I think the real answer to your question
7 is that the prior architect that designed the project
8 did not fully comprehend the requirements of a nursing
9 home and maybe came in a little bit low in his
10 estimate. And I don't want to throw him under the
11 bus, but, you know, essentially he was way off.

12 CHAIRPERSON OLSON: Well, thank you for
13 the honest answer because that does explain it better.

14 Mr. Sewell.

15 MEMBER SEWELL: I'm sorry.

16 I want you to correct something that I'm
17 about to say as to whether or not it's accurate.

18 It looks like there's a retirement community
19 here and there's a need for another category of
20 service. This is long-term care for that population.
21 Okay?

22 But there's a service area where, according
23 to the State agency report, if you had these 71 beds,
24 they would probably be adequately utilized by your

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1 on-site population but it will just do further damage
2 in the region because of these 103 facilities that are
3 not operating at target occupancy because, if you
4 didn't have them, your retirement community of people
5 that needed long-term care would have to use one of
6 those 103 facilities.

7 Now, is that unfair?

8 MR. SHEETS: Well, I don't want to say
9 that's unfair. I think that's a good question.

10 MEMBER SEWELL: No, not by you but by me
11 to say that.

12 MR. SHEETS: No, I don't think so
13 at all.

14 But I do think that -- you have to
15 understand that there was no opposition filed on this
16 project, that if you look at the State agency report
17 in Table 3, there are quite a few facilities within
18 30 minutes. In fact, there are 138 facilities within
19 30 minutes.

20 So the vast number of nursing homes that are
21 out there -- there's obviously a lot of nursing homes
22 out there. Some of them are operating at capacity and
23 some aren't. But this project is so small that it did
24 not draw anybody's attention. And because the beds

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1 are essentially captive anyway -- I mean, we didn't
2 have any opposition.

3 So I guess my point is, in order for us to
4 serve the people in our community, we'd like to be
5 able to keep that option open for a skilled nursing
6 unit, and we can't do that financially unless we have
7 the ability to have a Medicare unit that admits from
8 the community.

9 MEMBER SEWELL: Uh-huh.

10 MR. SHEETS: Also, let me -- let me just
11 stop there.

12 MR. TALBOT: Yes, a little bit of
13 comments on that.

14 Working in the state for 20 years and with
15 the public aid system, Medicaid I so often see in the
16 business type -- 20 days, residents are going to
17 another facility because they don't have a co-pay or
18 they're shopping around. They're told -- you know,
19 just like the hospitals -- "Oh, I'm sorry" -- to find
20 another place to live.

21 What we're looking for in this community is
22 a reverse ACO. This is not only going to benefit the
23 community and the ownership; it's going to benefit the
24 State. Over three years we would have saved the State

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1 of Illinois \$1.8 million if we'd have had this unit
2 on-site and that's substantial. And that could change
3 if we're able to keep our residents past the 20 days,
4 serve them, rehab them.

5 Once they're done with their Medicare
6 skilled services for a broken hip or whatever it may
7 be, maybe they're still not ready to go home. They
8 will then go to the ALF side, and if they don't have
9 enough money, we will assist them filing for Medicaid.
10 Or if they already have it, transition to the ALF for
11 maybe another 30 days at a 60 percent lower rate. And
12 then from there our social workers will find them --
13 if they're qualified for -- low-income housing,
14 apartments, transition with a family member -- which
15 the ACO model is looking -- so we're reversing this
16 model. And I've done this in North Carolina and other
17 states and it's worked wonderful.

18 And this is something very unique. But in
19 order to properly do this so we don't have to use the
20 terms "If you're not able to pay, you have to leave"
21 or "We don't have this," we want to -- we need the
22 community input on the Medicare to help offset that
23 cost and still retain our residents.

24 MR. CHASE: Just to add to --

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1 thank you, Bob.

2 Just to add to everything that's being said,
3 Asbury Court is extremely involved in the community.
4 We've been around for quite a long time, and we're
5 active members of the community. We host a lot of
6 open houses for the community. Everyone knows us,
7 everyone -- you know, when the time is right -- they
8 all say, "When Mom turned that certain age and needed
9 that certain need, we always knew she and Dad were
10 going to come to Asbury Court."

11 People constantly call, people -- you know,
12 word of mouth is that we are opening up a skilled
13 facility. People from the community call and say,
14 "Will you admit Mom, Dad" -- you know, from other --
15 you know, from anywhere -- "into your skilled
16 facility?"

17 We are very reputable in the community.
18 We have many situations where couples move in, and
19 sometimes we have to not allow them to move in because
20 one of the spouses needs the skill whereas the other
21 one is okay in the supportive living. By us being
22 able to admit people from the community, we're able to
23 accommodate situations like that.

24 Like I said, there's a great deal of demand.

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1 We are constantly being called about our long-term
2 care facility to see if we can admit people from the
3 community, as well. So I just wanted to add that in,
4 as well.

5 CHAIRPERSON OLSON: Yes, Frank.

6 MR. URSO: Chuck, I just want to ask you
7 a question. You said something about a captive
8 audience.

9 Am I -- to that -- am I saying it correctly?

10 In your prior statement you said something
11 about "captive."

12 (No response.)

13 MR. URSO: Okay. Well, I --

14 MR. SHEETS: If I did, I'm getting old
15 because I don't remember.

16 MR. URSO: All right. Well, I mean --
17 when you said that -- when you said that, in my mind
18 that triggered, "Well, that's because this is a
19 continuum of care variance." That's what I'm talking
20 about.

21 MR. SHEETS: Correct.

22 MR. URSO: Okay. But on the other hand,
23 you're saying you want to get rid of the variance, so
24 then you won't have a captive audience, so to speak,

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1 anymore.

2 MR. SHEETS: Well, our goal is to have
3 priority admissions from the community. I mean,
4 that's what we want to do, but we want to be able to
5 have a Medicare community.

6 I mean, we want a therapy unit in the
7 building that can admit from the outside. Otherwise,
8 we won't have the sources of funds to support, you
9 know, the SNF. We've done the pro formas and it just
10 doesn't work.

11 CHAIRPERSON OLSON: Other comments or
12 questions from Board members?

13 Senator.

14 MEMBER DEMUZIO: In one of the findings
15 here, it's about your financials.

16 Could you tell me, has your -- have you had
17 an opportunity to change or reverse the fact that you
18 do not have a letter of commitment from the bank?

19 It says that the -- the letter explicitly
20 says that they are not making a commitment.

21 MR. SHEETS: That's correct, Senator.

22 And as you probably know, getting anything
23 from the bank is difficult. We thought we would have
24 it before we came before you today, but we don't have

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1 it yet.

2 We're certainly willing to limit the
3 condition on the permit, if that becomes an issue,
4 that we will provide you a letter of commitment within
5 90 days.

6 MEMBER DEMUZIO: But as of today you do
7 not have that?

8 MR. SHEETS: We do not have that.

9 MEMBER DEMUZIO: Thank you.

10 CHAIRPERSON OLSON: Other questions or
11 comments?

12 (No response.)

13 CHAIRPERSON OLSON: Is the Board
14 interested in putting that condition on the motion,
15 that they present us with a letter of commitment
16 within 90 days?

17 MEMBER DEMUZIO: I think so.

18 CHAIRPERSON OLSON: And if not --

19 MEMBER DEMUZIO: I'd like to make that
20 motion.

21 CHAIRPERSON OLSON: And if not, what?

22 If not, what? Invalid -- the permit isn't
23 valid? Or we take it back and forth -- they would
24 need to come back before us and explain why they don't

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1 have that?

2 MEMBER DEMUZIO: I think so.

3 CHAIRPERSON OLSON: Can you live with
4 that as part of your motion?

5 MR. SHEETS: We can.

6 CHAIRPERSON OLSON: All right. I'm
7 seeing no further comments so --

8 MR. URSO: So -- excuse me. Is that
9 within 90 days of today?

10 MR. SHEETS: Yes.

11 MR. URSO: Yes? Okay.

12 MS. AVERY: It is?

13 CHAIRPERSON OLSON: As opposed to
14 90 days of what?

15 MR. URSO: Completion date or whatever.

16 CHAIRPERSON OLSON: Oh.

17 MS. AVERY: No, I . . .

18 CHAIRPERSON OLSON: 90 days from today
19 is what . . .

20 MR. SHEETS: (Mr. Sheets nodded his head
21 up and down.)

22 CHAIRPERSON OLSON: Okay. Roll call
23 vote, please.

24 MEMBER BURDEN: Excuse me. Would you

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1 mind repeating what the motion is.

2 CHAIRPERSON OLSON: Oh, I'm sorry.

3 We're voting on a motion to approve
4 Project 14-022, Asbury Court Nursing & Rehabilitation
5 Center, to establish a 71-bed skilled nursing unit
6 with a condition that they will provide to the Board,
7 within 90 days of today, a letter of commitment from
8 the bank.

9 And if they don't have that letter of
10 commitment in 90 days, they will appear before the
11 next scheduled Board meeting after that 90 days, which
12 is probably after November -- probably next year.

13 MEMBER SEWELL: December.

14 CHAIRPERSON OLSON: We don't have a
15 making in December, do we?

16 MS. AVERY: Yes, December 16th.

17 CHAIRPERSON OLSON: December 16th.

18 Okay. Roll call vote, please, Nelson.

19 MR. AGBODO: Okay. Thank you, Madam
20 Chair.

21 The motion was made by Mr. Hayes; seconded
22 by Mr. Sewell.

23 Mr. Bradley.

24 MEMBER BRADLEY: They seem to have

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1 rationalized their situation. I think they have more
2 realistic plans than they did when they came for the
3 previous permit.

4 And, therefore, I vote yes.

5 MR. AGBODO: Dr. Burden.

6 MEMBER BURDEN: I will vote yes although
7 I'm somewhat conflicted with some of the issues that
8 are varied from the State Board standards, the
9 availability of the funds being significant, which we
10 put in our wording of our response to their
11 application, and, also, the maldistribution impact.
12 It's a narrow margin when you're dealing with
13 Medicaid, having dealt with it for 45 years, a little
14 longer than you guys.

15 But, nonetheless, I'll vote yes.

16 MR. AGBODO: Senator Demuzio.

17 MEMBER DEMUZIO: Thank you.

18 I'm going to go ahead and vote yes, although
19 I do have some reservations. Certainly, the motion
20 now, having you come back within a 90-day period on
21 your financials, makes it a little easier for me to do
22 that.

23 Normally with the findings of the State
24 Board -- or with our Board -- I usually, you know,

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1 have to take a hard look at that. I do know your
2 service area with 103 facilities and all of -- the
3 30-minute proximity still causes me some concern.

4 But I look forward to seeing you back to
5 90 days with that letter, and I vote yes.

6 MR. AGBODO: Judge Greiman.

7 MEMBER GREIMAN: I'll vote yes for
8 reasons previously stated.

9 MR. AGBODO: Mr. Hayes.

10 VICE CHAIRMAN HAYES: I'll vote yes for
11 the reasons stated. I think that this project can add
12 to the area and I appreciate that.

13 And I vote yes.

14 MR. AGBODO: Mr. Sewell.

15 MEMBER SEWELL: I vote yes.

16 I think that there's a concept being
17 presented here that sounds like it will work in
18 context with -- even in spite of some of the State
19 agency report content. And it does make me feel
20 better with the 90-day condition on the commitment
21 letter.

22 So I vote yes.

23 MR. AGBODO: Madam Chair Olson.

24 CHAIRPERSON OLSON: I vote yes, as well,

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1 for a few reasons, and one is what Mr. Sewell just
2 stated. I really think this reverse-ACO concept is a
3 pretty incredible concept, and I can see how, if it
4 works the way you make it sound it works, that will be
5 a great savings to the State of Illinois and a good
6 model for the patients that are going to be involved.

7 The other reason is, with 103 nursing homes
8 in this service area and not one letter of opposition,
9 that speaks volumes.

10 So I'm going to vote yes, as well.

11 MR. AGBODO: Thank you.

12 I have 7 votes in the affirmative.

13 CHAIRPERSON OLSON: Motion passes.

14 Thank you.

15 MR. SHEETS: Thank you very much.

16 CHAIRPERSON OLSON: Okay. Moving on, we
17 have Applicants -- oh, the court reporter needs a
18 break.

19 About a 10-minute break. I'm sorry.

20 (Recess taken, 3:03 p.m. to

21 3:11 p.m.)

22 (Member Demuzio and Mr. Dart left
23 the proceedings.)

24 - - -

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1 CHAIRPERSON OLSON: Okay. Next, we have
2 Project 14-023, University of Chicago Medical Center,
3 ambulatory care medical office building.

4 Can we have the Applicant to the table?

5 For the record, Senator Demuzio has now
6 left.

7 (Discussion off the record.)

8 CHAIRPERSON OLSON: Okay. The Applicant
9 will state your name and be sworn in, please.

10 The COURT REPORTER: Would you raise
11 your right hands, please.

12 (Five witnesses duly sworn.)

13 THE COURT REPORTER: Thank you. And
14 please just state your names down the row.

15 MR. OURTH: Joe Ourth.

16 CHAIRPERSON OLSON: I'm sorry.
17 Please -- we're counting. We can't count to six,
18 apparently.

19 Please introduce yourselves.

20 MS. O'KEEFE: Sharon O'Keefe, president,
21 University of Chicago Medical Center.

22 MR. BEBERMAN: John Beberman, director
23 of capital budgets.

24 DR. VOKES: Everett Vokes, chairman,

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1 department of medicine.

2 MR. CAPICCHIONI: Marco Capicchioni,
3 vice president of facilities design and construction.

4 CHAIRPERSON OLSON: Thank you.

5 State Board staff report, please, George.

6 MR. ROATE: Thank you, Madam Chair.

7 The Applicant proposes to construct a
8 four-story ambulatory care medical office building at
9 the northwest corner of 143rd Street and LaGrange Road
10 in Orland Park.

11 The anticipated cost of the project is
12 \$66.9 million. The anticipated project completion
13 date is June 30th, 2018. There was no public hearing
14 requested for this project. There were letters of
15 support and opposition.

16 There's one negative finding in the area of
17 1110.3030, clinical services other than categories of
18 service, and that is based on the potential that it
19 could provide a negative impact on other providers in
20 the planning area.

21 Thank you, Madam Chair.

22 CHAIRPERSON OLSON: Presentation for the
23 Board, please.

24 MS. O'KEEFE: Thank you very much.

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1 First, I'd like to thank Mr. Constantino and
2 other members of the staff for their work on the staff
3 agency report. It's very much appreciated.

4 We are here today to seek approval to
5 construct a four-story ambulatory care facility in the
6 village of Orland Park. This project would be the
7 culmination of a joint planning effort with Village
8 leadership, and you heard from them earlier this
9 morning.

10 The Village has a desire to develop this
11 property and to bring advanced medical care to area
12 residents, and the medical center has a desire to
13 expand access to patients in need of advanced medical
14 treatment, but we also are interested in this project
15 to serve the large base of patients that we already
16 care for.

17 Over the past year we have had close to
18 95,000 visits at our Hyde Park campus from patients
19 that came from the Orland Park area, and you heard
20 earlier from patients the burden that this creates for
21 their patients -- for themselves and their families as
22 they travel to receive care.

23 The facility would include clinical
24 specialties in which the University of Chicago

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1 Medicine excels and for which there is high demand in
2 the area. The specialties planned for the Orland Park
3 facility include medical oncology, radiation oncology
4 and infusion therapy, along with orthopedic, women's
5 health, pediatrics, gastroenterology, cardiology, and
6 an array of surgical subspecialties.

7 Our specialists have a history of working
8 hand in hand with clinical colleagues in the
9 community, and the services provided in this facility
10 would complement the care offered by local physicians
11 and hospitals. This actually is reinforced by the
12 13 letters of support that we received.

13 These letters came from patients,
14 physicians, community leaders, and from Donna
15 Thompson, the CEO of Access Community Health Network.
16 There was actually no opposition from any of the
17 nine hospitals in the planning area.

18 Our presence in the community would allow us
19 to continue to collaborate with area providers who
20 currently refer patients to the medical center in
21 Hyde Park and to make access to services for their
22 patients a bit easier.

23 The population in the service area is
24 growing and is aging. With these demographics the

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1 incidence of disease increases. The need for
2 specialty medical services is projected to
3 significantly outpace the existing supply in the area
4 by 2018, which is the projected date of our project
5 completion.

6 The number of annual outpatient visits in
7 the service area is expected to grow by close to
8 700,000 visits, topping out at 5.7 million by 2018,
9 with approximately half of those visits attributable
10 to specialty medicine, surgery, and pediatrics. This
11 would actually translate into a need for an additional
12 415 new exam rooms in the area.

13 The service area also has need for
14 additional physicians. In 2013 there was a need for
15 86 more adult specialty physicians, including
16 hematology/oncology, and 89 more surgeons, including
17 those specializing in orthopedics. This current
18 shortfall of physicians suggests that some patients
19 need to leave the service area to seek treatment. The
20 University of Chicago Medicine physicians who would be
21 practicing in this new facility would make available
22 specialty care providers to better meet the current
23 demand.

24 Interestingly enough, academic medical

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1 centers make up only 6 percent of the hospitals in
2 America, and we offer highly differentiated specialty
3 care, including care for patients with complex
4 conditions for whom there is often no standard
5 treatment options.

6 Specialized services would make accessible,
7 for patients in this area, clinical trials for cancer
8 patients, resources for women with extremely high-risk
9 pregnancies, and coordinated care for patients with
10 complex chronic conditions such as diabetes and heart
11 failure. Our presence in the community would
12 eliminate the need for patients to travel a great
13 distance for these types of services. As we have
14 heard from our patients earlier today, they would
15 welcome this convenience.

16 The area to be served by this facility is
17 actually socioeconomically diverse, with both
18 prosperous areas as well as towns and communities that
19 are far more economically challenged. It is home to
20 many federally qualified health centers and community
21 health centers. These primary care providers need
22 successful specialty services for their patients.

23 University of Chicago Medicine is one of the
24 largest Medicaid providers in the state. We are

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1 committed to serving all patients in the area
2 regardless of payer type. The financial assistance
3 and charity care policies in place at our Hyde Park
4 facility would be available to patients at this site
5 in Orland Park.

6 Unlike many other health systems with
7 multiple ambulatory locations dispersed throughout the
8 region, this actually would be the first for the
9 University of Chicago Medicine, a big departure from
10 our home base in Hyde Park.

11 Changes in the health care marketplace are
12 shifting a greater percentage of care to the
13 ambulatory setting. They're demanding more
14 coordinated care and, most assuredly, are emphasizing
15 convenience and ease of access. Ambulatory expansion
16 is happening regularly across the country and in our
17 local market.

18 To remain competitive, University of Chicago
19 Medicine needs to improve the accessibility to
20 specialty care in areas with a demonstrated demand and
21 in areas where we already have a strong, established
22 patient base. As we carefully plan for ambulatory
23 expansion, Orland Park is the ideal location for our
24 facility due to many of the reasons I have outlined.

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1 In filing our application we are pleased
2 that the SAR found that we complied with eight of the
3 nine Board criteria. The sole negative finding was
4 that, for the nine service area hospitals, the
5 diagnostic and treatment machines were underutilized
6 according to State standards.

7 We thoroughly considered the potential
8 impact our project might have on these existing
9 providers. Our analysis of the data indicates the
10 demand for medical services, including diagnostic and
11 treatment modalities, will outpace supply within the
12 next five years. These growth patterns will most
13 assuredly increase utilization of the existing
14 providers.

15 In planning for the Orland Park facility, we
16 calculate that our facility can meet target
17 utilization rates solely by accommodating a portion of
18 the incremental growth in this area. By capturing
19 approximately 18 to 30 percent of the incremental
20 growth, we would achieve utilization rates. Serving
21 this incremental growth would not negatively impact
22 current provider volumes.

23 While we considered many options as part of
24 our planning, including smaller projects, we believe a

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1 larger facility, hosting a number of specialists and
2 subspecialists, along with the needed diagnostic and
3 treatment modalities, is most convenient for patients
4 with complex illnesses and better for patient care.

5 We are pleased to be partnering with the
6 Village of Orland Park on this project and excited
7 about the prospect of bringing an advanced level of
8 care to a growing community and to a service area
9 where we already have a loyal, established patient
10 base.

11 We appreciate your consideration of the
12 project and are pleased to answer any questions.

13 CHAIRPERSON OLSON: Thank you.

14 Questions or comments from the Board?

15 (No response.)

16 CHAIRPERSON OLSON: I have a question,
17 just kind of an interest question, not really -- do
18 you -- what is your best guesstimate of your patient
19 mix in the new facility, existing patients versus
20 new patients?

21 Have you thought about that, or is it
22 just -- I mean, I know it's just a number, but I'm
23 just kind of curious.

24 MS. O'KEEFE: Well, at peak utilization

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1 of this facility by State standards, we probably have
2 something like 160,000 visits. We had 95,000 visits
3 currently at our Hyde Park -- that's visits, not
4 patients.

5 With the growth I would say that it's
6 probably going to be, you know, well under 50 -- maybe
7 a little under 50 percent of established care and then
8 50 percent growth.

9 CHAIRPERSON OLSON: And if I heard you
10 correctly, I believe, going by this, as well, that the
11 opposition to your project is not coming from any of
12 the area hospitals.

13 MS. O'KEEFE: There was no opposition
14 filed by any of the nine planning area hospitals.

15 CHAIRPERSON OLSON: Okay. Thank you.
16 Other questions or comments?

17 VICE CHAIRMAN HAYES: Madam Chair.

18 CHAIRPERSON OLSON: Yes, John.

19 VICE CHAIRMAN HAYES: Could you explain
20 maybe a little bit more about some of the opposition
21 comments that were made? Specifically they were
22 talking not about, I would say, this project but
23 specifically about an adult Level I trauma center.

24 And could you explain that issue a little

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1 bit from your perspective?

2 MS. O'KEEFE: Sure.

3 I appreciate the opportunity to actually
4 comment on the entire issue of trauma and, I would
5 say, violence on the south side of Chicago.

6 So the violence, actually, on the south side
7 of Chicago and in Chicago in general is actually a
8 tragic set of circumstances. Far too many young
9 people are losing their lives --

10 CHAIRPERSON OLSON: Excuse me. I don't
11 mean to interrupt, but I think this question needs to
12 be answered on the next application. I don't think
13 it's . . .

14 (Discussion off the record.)

15 VICE CHAIRMAN HAYES: Well, in the
16 public participation, you know, they basically talked
17 about this project as opposed to the other project on
18 our agenda. But you can . . .

19 MS. AVERY: I was thinking that because
20 this one -- the second one is right there in the
21 Chicago area, whereas -- as opposed to the other is in
22 Orland.

23 But if you want to go --

24 CHAIRPERSON OLSON: Yeah. I'm sorry.

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1 I stand corrected.

2 Please start again.

3 MS. O'KEEFE: Anyway, I'd be happy to
4 comment on the Level I.

5 As I said, violence on the south side of
6 Chicago and, actually, in Chicago in general is a
7 tragic set of circumstances. Far too many young
8 people are losing their lives too early in their life
9 cycle, and, clearly, our focus needs to be on
10 eliminating or decreasing the level of violence.

11 Both at the university and at the medical
12 center we're involved in many initiatives that are
13 focused on reducing the incidence of trauma and
14 particularly -- penetrating trauma or gunshot wounds
15 as a subset of all trauma is a particularly vexing
16 issue and an emotional issue.

17 We, like many other hospitals, are committed
18 to saving lives, and the way we currently participate
19 in the trauma system is by being a Level I pediatric
20 trauma center, which we have been for a number
21 of years, as well as one of three regional burn
22 centers.

23 Our pediatric trauma center served, last
24 year, 320 trauma cases for children under 16, and

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1 that's the age limit by the State. 55 of those or a
2 little under 20 percent were gunshot wounds that were
3 inflicted in the local community. So we serve the
4 vast majority of children on the south side of Chicago
5 for trauma.

6 Trauma in general, I would say, by its
7 nature, if you turn to the adult side, is -- as well
8 as for children -- is random and, I would say,
9 unpredictable in nature, so the care of trauma
10 patients actually requires a system of care that
11 involves multiple hospitals and a wide variety of
12 providers, everywhere from prehospital providers --
13 and we heard from some of the Chicago Fire Department
14 prehospital providers today -- all the way through
15 postacute care, to serve this patient population.

16 So expanding the system of trauma care in
17 Chicago requires careful consideration and, actually,
18 collaboration with the EMS community, the trauma
19 providers, the physicians and nurses who take care of
20 trauma patients, and we are currently in discussions
21 with, actually, all of the medical directors of trauma
22 systems, trauma centers in Chicago, and other
23 facilities to both collaborate and look at what is the
24 best possible way to organize a trauma system --

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1 trauma care in Chicago to best meet the needs of the
2 area, and those discussions are going on at this point
3 in time.

4 And we've done a thorough analysis of the
5 impact on the University of Chicago Medicine of a
6 trauma center on the adult side, both from an
7 operational perspective and a bed demand, and, also,
8 where patients would be coming from in the region
9 because they would most likely be viewed directly --

10 MR. URSO: Excuse me. May I ask you a
11 question just to clarify?

12 Are your comments more relative to your
13 project that's further down on the agenda or . . .
14 I mean, I think that's what we're discussing at this
15 point.

16 CHAIRPERSON OLSON: I just want to
17 caution the Board members that -- and I appreciate
18 your willingness to answer the question, but the
19 project that's before us is for the ambulatory medical
20 building.

21 MS. O'KEEFE: Correct.

22 CHAIRPERSON OLSON: So I don't want --

23 MR. URSO: In other words --

24 MS. O'KEEFE: It's your call.

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1 CHAIRPERSON OLSON: I want Board members
2 to keep those -- and I do appreciate your answering
3 the question, but my concern is we're going to muddy
4 the water here with a project that -- there is no
5 project for that right now --

6 MS. O'KEEFE: There is not.

7 CHAIRPERSON OLSON: -- so I just don't
8 want to --

9 MS. O'KEEFE: There is not. This is in
10 response, I believe, to the public comments.

11 CHAIRPERSON OLSON: I understand and
12 I appreciate you doing that, but our rules state that
13 we're supposed to stick to the projects we're hearing.

14 (Discussion off the record.)

15 MS. O'KEEFE: I don't know if I addressed
16 Mr. Hayes' question, though.

17 MR. URSO: You were.

18 CHAIRPERSON OLSON: Thank you for
19 answering the question. I appreciate it.

20 Other questions or comments?

21 VICE CHAIRMAN HAYES: Thank you very
22 much.

23 CHAIRPERSON OLSON: Mr. Sewell.

24 MEMBER SEWELL: Yes.

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1 I guess I want to understand what the state
2 of the existing providers is in the Orland Park area
3 with respect to some of the things that you're
4 bringing in in your proposal, like MRI and, you know,
5 CT scanning.

6 I mean, is it that there's not enough of it
7 or it's aged out or what?

8 MS. O'KEEFE: Our interest in having the
9 ancillary testing within the building is really driven
10 by convenience for patients and for coordination of
11 care for patients.

12 MEMBER SEWELL: So I'm -- did I not
13 hear, though -- maybe this is a question more for the
14 staff, for George.

15 This whole criterion about, you know, the
16 other clinical services and the idea that this project
17 would have a negative impact on providers in the area,
18 is that because the providers don't have enough
19 capacity when it comes to these services that the
20 University of Chicago is proposing to bring in? Or
21 are they in disrepair? Or . . . out of date?

22 I mean, I don't have a feel for what we're
23 talking about.

24 MR. ROATE: You are correct, Mr. Sewell;

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1 however, what the State Board staff report says is
2 there's a capacity -- there's a potential for negative
3 impact, meaning that there are some underused
4 facilities in the area. And while we can't predict
5 that with any accuracy in the future, the potential
6 does exist.

7 MEMBER SEWELL: And then I think I heard
8 in your presentation that you're projecting that -- a
9 couple things.

10 One is that you'll have a share of roughly
11 18 to 30 percent of the incremental growth in those
12 services in the Orland Park area and you think, in
13 general, because of growth in that area, that the
14 demand for services will exceed the current supply
15 without you there in the next five years.

16 Is that what you're saying?

17 MS. O'KEEFE: Yes.

18 MEMBER SEWELL: Okay. I just wanted to
19 make sure I was -- this is sort of harder to grasp
20 than beds and services, you know, when you talk about
21 other categories of services. It's a pretty broad
22 thing, "other," you know.

23 MS. O'KEEFE: Uh-huh.

24 CHAIRPERSON OLSON: Other questions or

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1 comments for the Applicant?

2 (No response.)

3 CHAIRPERSON OLSON: Seeing none, I'll
4 call for a roll call vote, please.

5 MR. AGBODO: Thank you, Madam Chair.
6 Mr. Bradley.

7 MEMBER BRADLEY: When I was running the
8 health plan, my last job, we had an office in downtown
9 Chicago, small administrative staff, and four of my
10 key people lived in Orland Park. And they came to me
11 and said, "Look. We're spending an hour, hour and a
12 half each way driving up here on the Dan Ryan to work.
13 You'd get more benefit from us spending half that time
14 in the office in Orland Park if you'd open an office."

15 And I did open an office down there, and we
16 got much better employee morale, better attendance at
17 work, and the whole thing worked very well. And
18 that's simply --

19 CHAIRPERSON OLSON: Mr. Bradley, I've
20 just been told I goofed up here.

21 I haven't called for a motion or a second
22 so I --

23 MEMBER BRADLEY: I move.

24 CHAIRPERSON OLSON: Can I have a second?

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1 MEMBER BURDEN: Second.

2 CHAIRPERSON OLSON: Thank you.

3 I'm sorry to interrupt.

4 MEMBER BRADLEY: This is a very simple
5 issue, and it's not just four staff members who didn't
6 want to commute. It's a lot of sick people and
7 parents of sick people who don't want to spend an hour
8 or hour and a half on the Dan Ryan each way to get
9 services for their child.

10 This is simply the institution reaching out
11 to -- enlarging the population it's already serving
12 and saying "We can make your life better and still
13 make our services available to you."

14 And I think it's a very simple open-and-shut
15 case and I vote yes.

16 MR. AGBODO: Thank you.

17 Dr. Burden.

18 MEMBER BURDEN: I was -- I'm with
19 Mr. Bradley. I don't know if you guys can hear me.
20 This thing is not working, I guess.

21 MR. URSO: How about the one with the
22 wire?

23 MEMBER BURDEN: It doesn't matter
24 anyway. Mr. Bradley has pretty well articulated my

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1 sentiment with regard to this application. I believe
2 that there's no need to repeat what he said.

3 I vote yes.

4 MR. AGBODO: Judge Greiman.

5 MEMBER GREIMAN: Well, 52 years ago
6 I handled a real estate deal in the southern suburbs
7 for 50 -- on a tract of land for 50 houses to be
8 built. And the people who lived there incorporated
9 and called themselves Orland Park. And the mayor's --
10 the town hall -- the Village hall was in the mayor's
11 basement.

12 Now, in the 52 years since that happened,
13 Orland Park is an incredible, incredible center of
14 residents and commercial businesses in the southern
15 suburbs, and I think it's going to continue to grow in
16 the next 50 years, as well.

17 So I vote aye.

18 MR. AGBODO: Mr. Hayes.

19 VICE CHAIRMAN HAYES: I'm going to
20 vote yes because I think the other providers in the
21 A-4 planning area did not oppose this project, and
22 I think the clinical services that are provided there
23 will enhance the medical services in the Orland Park
24 and southwest suburbs area.

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1 MR. AGBODO: Mr. Sewell.

2 MEMBER SEWELL: Yes. I vote yes for
3 reasons stated.

4 MR. AGBODO: Madam Chair Olson.

5 CHAIRPERSON OLSON: I vote yes for
6 reasons stated, as well.

7 MR. AGBODO: I have 6 votes in the
8 affirmative and 3 absent.

9 CHAIRPERSON OLSON: The project passes.
10 Good Luck.

11 MS. O'KEEFE: Thank you very much for
12 your support.

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1 CHAIRPERSON OLSON: And I think you can
2 please stay right there because now we're moving on to
3 applications subsequent to intent to deny, I-01,
4 14-013, University of Chicago Medical Center in
5 Chicago.

6 MS. O'KEEFE: We have a couple other --

7 CHAIRPERSON OLSON: We have two
8 additional people?

9 MS. O'KEEFE: Swapping out two.

10 CHAIRPERSON OLSON: Okay. So if you
11 would state your names and be sworn in.

12 The COURT REPORTER: Would you raise
13 your right hands first, please. Not -- you guys are
14 good.

15 The two of you on the end.

16 (Two witnesses duly sworn.)

17 THE COURT REPORTER: Thank you. And
18 would you just state your names for me, please.

19 MS. ALBERT: Debbie Albert.

20 DR. WEBER: And Stephen Weber,
21 W-e-b-e-r.

22 THE COURT REPORTER: Thank you.

23 CHAIRPERSON OLSON: George, State Board
24 staff report, please.

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1 MR. ROATE: Thank you, Madam Chair.

2 The Applicant is proposing to relocate
3 122 medical/surgical beds and 32 intensive care beds
4 from the Bernard A. Mitchell Hospital to the Center
5 for Care and Discovery on the University of Chicago
6 Medical Center campus. In addition to this project,
7 they've proposed to increase their intensive care beds
8 by 12 beds from 114 to 126 and increase observation
9 beds from 15 to 46.

10 The cost of the project is \$123.5 million.
11 There's an anticipated project completion date of
12 September 30th, 2017.

13 The Applicant received an intent to deny at
14 the July 14th, 2014, State Board meeting. The . . .
15 there's negative criteria found in the area of size of
16 project and modernization.

17 Thank you, Madam Chair.

18 CHAIRPERSON OLSON: Presentation for the
19 Board?

20 MS. O'KEEFE: Thank you very much. The
21 hour is late here, so I will try to be brief.

22 Last month we came to you with a proposal to
23 build out two floors of shell space in our new
24 hospital that we refer to as the Center for Care and

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1 Discovery.

2 The Board's vote last month on intent to
3 deny the project indicated that we obviously did not
4 convey the importance of this project as well as we
5 had hoped. We appreciate the opportunity to return
6 here today to present further information about our
7 proposed project and to respond to the questions that
8 were raised by the Board at the previous hearing.

9 The shelled floors we propose to build out
10 would accommodate the relocation of 122 medical /
11 surgical beds, 32 ICU beds from the Mitchell Hospital
12 to the Center for Care and Discovery.

13 Second, it would expand our ICU capacity by
14 12 beds and would create capacity to accommodate the
15 growing number of patients requiring observation
16 status.

17 Questions at the last hearing focused on
18 two main areas of concern: First, why we needed to
19 modernize our beds and relocate them to the CCD
20 instead of remaining in Mitchell, and, second, why we
21 need to maintain a bed base of 338 med/surg beds, so
22 let me speak to each of these items.

23 As we looked to modernize our bed base, we
24 evaluated two different options, one to build out the

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1 shelled floors in the CCD and one to invest in the
2 Mitchell Hospital and modernize what is clearly an
3 aging facility. And I think you heard some of the
4 comments from our patients who had received care in
5 both facilities.

6 Maintaining Mitchell for long-term patient
7 care would require substantial upgrades to the HVAC
8 system, electrical and communication systems, and an
9 expansion of, actually, all of the patient rooms to
10 better accommodate modern medical technology. Due to
11 the intensity and the scope of the renovations, we
12 would actually need to close down units in Mitchell
13 during the construction, which would mean a loss of
14 60 beds at a time over a period of four years. The
15 cost of this project would be \$224 million.

16 This option is more costly and substantially
17 more disruptive to patient care than the alternative
18 option, which is to build out the shelled floors in
19 the CCD. Maintaining beds in Mitchell also does not
20 resolve the operational challenge created by caring
21 for patients in two separate facilities.

22 The other alternative we evaluated is one
23 that was proposed here, which is to build out the
24 shell space in the CCD, which would be a cost of

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1 \$123 million versus the 224, and would enable us to
2 locate -- colocate -- 92 percent of our adult beds
3 within one facility. This would put the vast majority
4 of our adult acute care in close proximity to our
5 operating rooms and the advanced technology base which
6 resides in the Center for Care and Discovery.

7 As this is shell space to be built out and
8 is currently not used for clinical functions, there
9 actually would be no disruption to the current
10 operations and we would be able to continue to serve
11 the patients in the volume that we do today with no
12 interruption in service.

13 After a thorough evaluation of the options,
14 we believe the build-out of the shell space for this
15 project is far superior as an option from a clinical,
16 financial, and an operational perspective.

17 This project is actually not proposed to add
18 med/surg beds but, rather, to maintain our current
19 licensed capacity of 338 adult med/surg beds. At the
20 July meeting questions were raised about whether the
21 current number of 338 was actually adjusted value
22 based on the historic utilization of this bed
23 category.

24 At the time of the approval of our 338 beds,

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1 which was in the fall of 2013, we demonstrated that we
2 needed the beds to overcome critical capacity
3 constraints in our med/surg bed base and in our
4 emergency department.

5 As you heard earlier from testimony from the
6 Chicago Fire Department, your approval of those
7 additional beds has greatly assisted us in resolving
8 our diversion problem. We have maintained a diversion
9 rate number to the emergency department of 1 percent
10 or lower since the beds have been put into use. This
11 reduction in diversion is important to our community,
12 as 77 percent of the patients we serve in the
13 emergency department are from the south side of
14 Chicago.

15 Our med/surg bed utilization rate has been
16 increasing over the past several months. Over the
17 past four years, our med/surg days have grown an
18 average of 6.3 percent per year, year over year. We
19 expect this trend to continue and drive our
20 utilization rate to achieve State standard well in
21 advance of the required CON rules.

22 In fact, over the last five months, we have
23 been achieving the State standard. Over the past
24 five months since we opened the additional 38 beds, we

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1 have actually been at 90.7 percent occupancy month
2 over month. We expect this trend to continue.

3 Any reduction in our med/surg bed capacity
4 would significantly impact our emergency department
5 performance and create access problems for patients in
6 communities that we serve.

7 We thank you for the opportunity to more
8 fully and clearly present this project and are pleased
9 to answer questions.

10 CHAIRPERSON OLSON: Thank you.

11 Questions or comments from Board members?

12 MEMBER GREIMAN: Yeah.

13 CHAIRPERSON OLSON: Justice.

14 MEMBER GREIMAN: So when you -- when you
15 got the first CON originally for this building, there
16 was no -- there was nothing for the third and
17 fourth floors; is that right?

18 MS. O'KEEFE: Correct.

19 MEMBER GREIMAN: So we all anticipated
20 that something would be up there, that it wouldn't be
21 vacant forever?

22 Is that a correct statement?

23 MS. O'KEEFE: Yeah. The intent when the
24 building was approved -- and, actually, John could

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1 maybe comment on it because he was here.

2 Those shell -- those two floors were shelled
3 with the intent of, at a future date, building them
4 out for clinical care in the building.

5 MEMBER GREIMAN: And you don't have
6 anything that you changed your mind about in the
7 period -- in that interim period now?

8 MS. O'KEEFE: No. Not at all.

9 MEMBER GREIMAN: Okay. Thank you.

10 CHAIRPERSON OLSON: Doctor.

11 MEMBER BURDEN: I appreciate this
12 clarification. I wasn't here the last time. I'm glad
13 I'm here this time. I appreciate what you had to say.

14 Thank you.

15 CHAIRPERSON OLSON: Other comments or
16 questions?

17 Richard.

18 MEMBER SEWELL: It looks like the --
19 according to the State agency report -- the intensive
20 care beds are justified and there's issues with the
21 medical/surgical beds, but according to this . . .
22 this table here but -- the thing in the executive
23 summary -- the table in the executive summary of the
24 State agency report --

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1 MS. AVERY: Page 3.

2 MEMBER SEWELL: There you go. Page 3.
3 That's a good way to put it.

4 It looks like you're off by like two beds.
5 Is that correct?

6 In terms of comparing what is there with
7 what's warranted through the target occupancy.

8 MR. ROATE: Yes. On that table that you
9 see on page 3, one thing I wish to point out that was
10 pointed out to the State Board -- or State Board
11 staff -- the numbers you see in the right column, the
12 number of beds warranted at the target occupancy, the
13 bed -- the numbers you see printed are based on
14 90 percent occupancy when in reality --

15 MEMBER SEWELL: 90.

16 MR. ROATE: -- they only need 88 percent
17 occupancy.

18 While that number -- the number over in that
19 right column -- would be -- it could be significantly
20 smaller, they still reflect, at the -- they still
21 reflect the two numbers for 2013 and 2014 being
22 beneath the appropriate percentile while the projected
23 figures for 2015, '16, '17, and '18 would still be
24 over.

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1 MEMBER SEWELL: These projections are
2 sort of perplexing. What are some of the factors that
3 go into them where you see the patient base going down
4 and going up?

5 I mean, do you have year-by-year population
6 estimates or something? Is that what's making that
7 happen?

8 MR. ROATE: Population estimates,
9 utilization trends.

10 MEMBER SEWELL: I see.

11 Okay.

12 CHAIRPERSON OLSON: Other questions?
13 Comments?

14 MR. ROATE: Madam Chair.

15 CHAIRPERSON OLSON: Yes.

16 Oh, yes. May I please have a motion --

17 MEMBER BRADLEY: So moved.

18 CHAIRPERSON OLSON: -- to approve
19 Project 14-013, University of Chicago Medical Center,
20 to build out shell space and add 12 intensive care and
21 29 observation beds?

22 MEMBER BRADLEY: So moved.

23 MEMBER BURDEN: Second.

24 CHAIRPERSON OLSON: Roll call, please.

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1 MR. AGBODO: Thank you, Madam Chair.
2 Motion made by Mr. Bradley; seconded by
3 Dr. Burden.

4 Mr. Bradley.

5 MEMBER BRADLEY: Again, as I recall,
6 this is a project that had a majority vote for it but
7 did not have the required statutory vote.

8 I was convinced before that this was a good
9 project and that there are no impediments in the State
10 agency report and I vote yes.

11 MR. AGBODO: Dr. Burden.

12 MEMBER BURDEN: I -- again, I'm
13 impressed that this addresses one of the issues since
14 I've been on this Board at that institution regarding
15 the bypass problems, which now appear to be corrected
16 substantially. That's about the essence of my
17 concern.

18 And I -- obviously, I vote yes for this
19 project.

20 MR. AGBODO: Judge Greiman.

21 MEMBER GREIMAN: Yes.

22 MR. AGBODO: Mr. Hayes.

23 VICE CHAIRMAN HAYES: Yes, for many of
24 the reasons stated and specifically the -- I think the

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1 CHAIRPERSON OLSON: We are now onto
2 other business. There is none.

3 Rules development, there's nothing.

4 No unfinished business.

5 So new business is in order. I think you
6 all have your financial report included in your
7 packet.

8 Are there questions regarding the financial
9 report?

10 (No response.)

11 CHAIRPERSON OLSON: Seeing none --

12 VICE CHAIRMAN HAYES: Are we moving
13 forward?

14 CHAIRPERSON OLSON: The financial
15 report.

16 VICE CHAIRMAN HAYES: You know, I -- my
17 question on the financial report --

18 THE COURT REPORTER: Could you use your
19 mic, please?

20 Could you use your mic? I'm sorry.

21 VICE CHAIRMAN HAYES: Yeah.

22 The question on the financial . . . my
23 question on the financial report is, you know --
24 basically, the cash balance is about \$6 1/2 million?

1 MS. AVERY: Yes.

2 VICE CHAIRMAN HAYES: And this actually
3 reflects -- the fiscal year 2014 is as of June 30th,
4 2014, so that's a full year; is that correct?

5 MS. AVERY: That's correct.

6 VICE CHAIRMAN HAYES: Okay. Could . . .
7 what would be the -- where -- what areas would we be
8 looking at on this cash balance sheet? And do you
9 expect it to stay at that level and increase the next
10 fiscal year?

11 MS. AVERY: It's hard to predict. It
12 depends on the number of applications and the size of
13 the projects that we get coming in in the next fiscal
14 year.

15 So it's been pretty steady. We haven't
16 declined but we also haven't had really large projects
17 that we've had in the past. So it's kind of hard to
18 predict it because it depends on what applications and
19 projects we have coming in.

20 VICE CHAIRMAN HAYES: Well, there could
21 be incremental expenses associated with this.

22 MS. AVERY: Oh, yes. The appropriations
23 that we get from the budget of management and
24 planning -- I think is the name of it -- is -- what

1 you see at the top was appropriated so we'll be okay.
2 We can't exceed those two amounts.

3 One amount is for what we split with IDPH,
4 1.6, I think -- 1.6 million -- and the Board gets
5 1.2 million.

6 But our actual cash balance of how much we
7 have coming in is dependent upon the application fees
8 that we have coming in the fund, that are put into
9 the fund.

10 (Member Burden left the
11 proceedings.)

12 VICE CHAIRMAN HAYES: Okay. But in the
13 fiscal year 2014, the revenue was about 2.1 million?
14 It's down from 2013 at 2.3 million?

15 MS. AVERY: Not that -- go ahead.
16 I'm sorry.

17 VICE CHAIRMAN HAYES: Yeah. And,
18 basically, the total expended is about 1 point -- is
19 1,875,000.

20 MS. AVERY: Yes.

21 VICE CHAIRMAN HAYES: So, you know,
22 that's where we're coming up with about -- what is
23 it? -- about 200,000 in increased cash balance?

24 MS. AVERY: Right. And, again, that has

1 to do with -- not that these positions are all that
2 amount, but we have two positions that were vacant,
3 the compliance position and then the assistant general
4 counsel position that was vacant. And our rent
5 decreased from -- but we'll see that go up with the
6 next year because we have moving expenses this time,
7 and our rent is going to increase.

8 VICE CHAIRMAN HAYES: Is going to
9 increase?

10 MS. AVERY: Yes.

11 VICE CHAIRMAN HAYES: Okay.

12 MS. AVERY: But we have more square
13 footage where we are now.

14 VICE CHAIRMAN HAYES: Okay. Do you
15 expect any statutory transfers as it was -- as it has
16 been in the past?

17 MS. AVERY: Last legislative session we
18 were not on the list of potential statutory transfers
19 but that can change.

20 MEMBER SEWELL: What are those? What's
21 a statutory transfer?

22 MS. AVERY: Where the Office of
23 Management and Budget transfers -- or borrows money
24 from our funds and supports the GRF.

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1 CHAIRPERSON OLSON: Money that --

2 MS. AVERY: But we get it back. They're
3 statutorily required to repay us for it. Not with
4 interest but we get the money back.

5 VICE CHAIRMAN HAYES: But that was
6 repaid --

7 MS. AVERY: Oh, yeah. We've been repaid
8 from the past years that we had the transfers.

9 VICE CHAIRMAN HAYES: -- transfers?

10 MS. AVERY: Yes.

11 VICE CHAIRMAN HAYES: Okay. Well, when
12 they talk about the different boards' missions, does
13 this Board's mission -- actually, it's one of the few
14 ones that actually generates revenue and specifically
15 actually generates cash.

16 MS. AVERY: Yeah. There are a couple,
17 like the . . . the Liquor Control Commission, the
18 sports finance. And I can't think of the others, but
19 those that can legally collect fees are based the same
20 way as we are -- or structured the same way we are.

21 VICE CHAIRMAN HAYES: Okay. Well,
22 thank you.

23 MS. AVERY: You're welcome.

24 CHAIRPERSON OLSON: Okay.

1 The 2013 hospital profile and 2013 annual
2 bed report were included on the disc in your packet.

3 Are there any questions?

4 THE COURT REPORTER: Excuse me?

5 CHAIRPERSON OLSON: The 2013 hospital
6 profile and 2013 annual bed report were included on
7 the disc in your packets.

8 Any questions?

9 MEMBER SEWELL: And in the box.

10 CHAIRPERSON OLSON: And in the
11 1700-page box.

12 MR. ROATE: Madam Chair, if I may point
13 out that the ASTC profiles are still under review and
14 have a little additional information. So the version
15 of the ASTC profiles that are on that disc and in the
16 box are still under revision and are not finalized.

17 CHAIRPERSON OLSON: Correct. Thank you
18 for that clarification.

19 MR. ROATE: Thank you.

20 CHAIRPERSON OLSON: The proposed meeting
21 dates for 2015 are in your packet. Please take a look
22 at them and, if you have any issues with them, call
23 Courtney.

24 And finally -- oh, what?

1 (Discussion off the record.)

2 CHAIRPERSON OLSON: As you look through
3 the first six months of the proposed meeting dates for
4 2015, is there any objection? Because they will start
5 putting contracts in place.

6 We have January, Bolingbrook; March, Normal;
7 April, Bolingbrook; June, Springfield; July,
8 Bolingbrook.

9 Can they start working on those contracts?
10 Any issues?

11 (No response.)

12 MS. AVERY: And I'm checking into the
13 June 2nd meeting location. It's a possibility that we
14 may be able to secure the Abraham Lincoln Library,
15 which has really good space and audiovisual equipment,
16 and I think it will be more readily accessible for the
17 hotels and things because I've gotten some feedback
18 about the Northfield Hotel & Conference Center. So
19 we're looking into checking the dates for the Abraham
20 Lincoln Library for June 2nd.

21 And that's near the Hilton and the Abraham
22 Lincoln Hotel and the State House Inn, so they're all
23 within the downtown area.

24 CHAIRPERSON OLSON: So the last item was

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1 a discussion on continuing ed and CON topics. I'm
2 losing my quorum.

3 Can we put that on --

4 MR. URSO: We need a motion to
5 approve --

6 CHAIRPERSON OLSON: Oh, I'm sorry.
7 We need a motion to --

8 MR. URSO: Mr. Bradley.

9 MEMBER BRADLEY: Yes?

10 CHAIRPERSON OLSON: We need a motion to
11 accept the hospital profile and the annual bed report.

12 MR. ROATE: Hospital profile, annual bed
13 report, and the -- well, the annual bed report and
14 hospital profile are pretty much one and the same.
15 The ESRD profile. It's just those two.

16 It's just those two.

17 MEMBER SEWELL: So moved.

18 CHAIRPERSON OLSON: May I have a second
19 to approve those two reports?

20 VICE CHAIRMAN HAYES: Second.

21 MR. ROATE: Is long-term care on there,
22 also? I believe it is.

23 MR. AGBODO: No. Long-term care is not.

24 MR. ROATE: Long-term care isn't. So

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1 it's just hospital and ESRD profiles.

2 MR. AGBODO: Yes.

3 MR. ROATE: I apologize.

4 CHAIRPERSON OLSON: I don't have a
5 quorum. I can't -- we'll have to bring --

6 MR. ROATE: Can we --

7 CHAIRPERSON OLSON: Can I just get you
8 to say yea or nay on accepting the ESRD and the
9 hospital profile?

10 All those in favor say aye.

11 (Ayes heard.)

12 CHAIRPERSON OLSON: Opposed, nay.

13 (No response.)

14 CHAIRPERSON OLSON: The motion passes.

15 MR. AGBODO: Thank you.

16 MS. AVERY: Mr. Bradley, are we
17 discussing the other topic under new business that you
18 wanted?

19 MEMBER BRADLEY: I think the Chairman
20 can just do that.

21 CHAIRPERSON OLSON: Oh, yeah. I know --
22 yeah.

23 MS. AVERY: Okay.

24 CHAIRPERSON OLSON: And I guess we'll do

1 this last discussion at the next meeting.

2 MS. AVERY: Well, basically, that one is
3 just for discussion on continuing ed topics.

4 At one point we are going to need a two-day
5 meeting. I think you all may recall that IHA and a
6 couple of other entities and interested parties
7 had some feedback that they wanted to relate to the
8 Board.

9 And since our agendas are really heavy, we
10 needed to pick a date where we could have a day-and-a-
11 half meeting in order to have discussions with the CON
12 communities and IHA.

13 I will recommend spring or early summer, so
14 the April or the June meeting. I don't think there's
15 any rush to do it right now.

16 CHAIRPERSON OLSON: If you have definite
17 opinions about that, let Courtney know, whether you'd
18 rather see that at the April or the June meeting, a
19 day-and-a-half meeting.

20 If you've got definite opinions one way or
21 the other, let Courtney know. Otherwise, we'll just
22 plan it.

23 MEMBER BRADLEY: I think it's a good
24 idea. But I think somewhere along the line we need to

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1 bring in somebody nationally who can tell us what the
2 trends are in CON boards across the country, rather
3 than just talk to other Illinois people.

4 I think we've got to find out what's going
5 on with similar institutions in, particularly, other
6 large states so that we have some context for the
7 discussions and decisions that we make.

8 CHAIRPERSON OLSON: Okay. We'll add
9 that to the list.

10 MS. AVERY: Okay.

11 (Member Bradley left the
12 proceedings.)

13 CHAIRPERSON OLSON: Anything else?

14 MEMBER GREIMAN: I'd move to adjourn.

15 MS. AVERY: No -- one other update, just
16 one more.

17 FYI, our House Bill 5986 was signed by the
18 Governor on -- yesterday -- and it is Public Act 1086.

19 CHAIRPERSON OLSON: We have a motion to
20 adjourn but --

21 VICE CHAIRMAN HAYES: Second.

22 MEMBER SEWELL: Second.

23 CHAIRPERSON OLSON: -- we can't adjourn.
24 We don't have a quorum.

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MEMBER GREIMAN: Bill's done. The meeting's over.

PROCEEDINGS CONCLUDED AT 3:57 P.M.

