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

OPEN SESSION

FEBRUARY 28, 2012

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NATIONWIDE SCHEDULING

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD
525 WEST JEFFERSON STREET, 2ND FLOOR
SPRINGFIELD, ILLINOIS 62761
217-782-3516

OPEN SESSION

FEBRUARY 28, 2012

Open session of the meeting of the State
of Illinois Health Facilities and Services Review
Board was held on February 28, 2012 at the
Bolingbrook Golf Club, 2001 Rodeo Drive,
Bolingbrook, Illinois.

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PRESENT:

- Dale Galassie - Chairman
- Ronald Eaker
- John Hayes
- John Burden
- Alan Greiman
- Kathy Olson
- Richard Sewell
- Robert Hilgenbrink

ALSO PRESENT:

- Michael Constantino - IDPH staff
- Cathy Clarke - Assistant
- Frank Urso - General Counsel
- Juan Morado - Assistant Counsel
- George Roate - Staff
- Bill Dart - IDPH Staff
- Claire Burman - IDPH Staff
- Michael C. Jones - IDHFS

REPORTED BY:

- Linda DeBisschop, CSR-MO, CSR-IL
- Midwest Litigation Services
- 401 N. Michigan Avenue
- Chicago, IL 60611

1 START TIME: 10:02

2

3 CHAIRMAN GALASSIE: I would like to call the
4 meeting to order. Good morning. Welcome board
5 members. Welcome visitors to a beautiful spring day
6 here in Chicago. I have friends who have just moved
7 here from LA. It's their first time living in the
8 Midwest and they are actually convinced this is a
9 Chicago winter and it's not that bad. Keep hoping.

10 Can we have a roll call, please, George.

11 MR. ROATE: Dr. Burden?

12 DR. BURDEN: Here.

13 MR. ROATE: Mr. Eaker?

14 MR. EAKER: Present.

15 MR. ROATE: Justice Greiman?

16 MR. GREIMAN: Here.

17 MR. ROATE: Mr. Hayes?

18 MR. HAYES: Here.

19 MR. ROATE: Mr. Hilgenbrink?

20 MR. HILGENBRINK: Here.

21 MR. ROATE: Ms. Olson?

22 MS. OLSON: Present.

23 MR. ROATE: Mr. Penn's absent. Mr. Sewell?

24 MR. SEWELL: Here.

1 MR. ROATE: Chairman Galassie?

2 CHAIRMAN GALASSIE: Present.

3 MR. ROATE: Seven present.

4 CHAIRMAN GALASSIE: Thank you very much.

5 Can I have motion to approve the agenda?

6 MS. OLSON: So moved.

7 MR. SEWELL: Second.

8 CHAIRMAN GALASSIE: Moved and seconded.

9 MR. ROATE: Motion made by Ms. Olson,
10 seconded by Mr. Sewell. Dr. Burden?

11 DR. BURDEN: Yes.

12 MR. ROATE: Mr. Eaker?

13 MR. EAKER: Yes.

14 MR. ROATE: Judge Greiman?

15 MR. GREIMAN: Yes.

16 MR. ROATE: Mr. Hayes?

17 MR. HAYES: Yes.

18 MR. ROATE: Mr. Hilgenbrink?

19 MR. HILGENBRINK: Yes.

20 MR. ROATE: Ms. Olson?

21 MS. OLSON: Yes.

22 MR. ROATE: Mr. Sewell?

23 MR. SEWELL: Yes.

24 MR. ROATE: Chairman Galassie?

1 CHAIRMAN GALASSIE: Yes.

2 MR. ROATE: That's eight.

3 CHAIRMAN GALASSIE: Thank you very much.

4 Can I have a motion to approve the minutes?

5 MR. HAYES: So moved.

6 CHAIRMAN GALASSIE: Moved and seconded. Any

7 issues on the minutes? Hearing none, voice vote,

8 all in favor.

9 MEMBERS IN UNISON: Aye.

10 CHAIRMAN GALASSIE: Opposed. Hearing none,

11 motion passes. Thank you.

12 Item number six on the agenda is post

13 permit items approved by the chair.

14 Mr. Constantino, please.

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

16 Permit number 7102, Alden Estates of Sherwood

17 approved December 27, 2011 for an alteration.

18 Permit number 1161, Satellite Dialysis of Glenview

19 approved for an alteration January, 12, 2010.

20 Permit number 11063, Proctor Community Hospital.

21 Alteration approved January 10, 2012. Permit number

22 071, Park Place Christian Community of Elmhurst,

23 15-month renewal approved January 10, 2012. Permit

24 number 09052, Memorial Hospital of Belleville,

1 nine-month permit renewal approved January 19, 2012.
2 Permit number 09035 Northshore University Health
3 System, Gurnee, eight-month permit renewal
4 approved February 20, 2012. Permit number 08089,
5 University of Chicago Medical Center of Chicago,
6 nine-month permit renewal approved on February 22,
7 2012. And permit number 10031, Pecatonica Pavilion,
8 18-month renewal approved February 28, 2012.

9 Thank you, Mr. Chairman.

10 CHAIRMAN GALASSIE: Thank you. We have some
11 people that have requested to make public comments
12 in support and in opposition. That comments will be
13 made when the actual agenda item comes up. We will
14 re-advise you of such and ask you to come to the
15 table to give public comment first, and then we will
16 have the organization come forward and give their
17 presentation if they so choose to the board. Thank
18 you.

19 We have some students here from Governor
20 State. If you would stand and be acknowledged.
21 They are an undergraduate class in health
22 administration and health planning, welcome here.
23 We are seeing health administration planning in
24 action.

1 (APPLAUSE)

2 Do well, we need all your help in the
3 future. Moving on to item number seven on the
4 agenda, items for state board action, in permit
5 renewal A-1 Resurrection Medical Center. Good
6 morning.

7 As you come to the table, if you would
8 introduce yourselves to our reporter and then we
9 will get you sworn in.

10 MS. CURTH: Nicolette Curth, C-U-R-T-H.

11 MR. GIACOMUSSI: Bruno Giacomussi.

12 MR. HAUPTMAN: Robert Hauptman.

13 CHAIRMAN GALASSIE: Swear them in please.

14 (ALL WITNESS SWORN)

15 CHAIRMAN GALASSIE: Thank you.

16 Mike, can we have a staff report?

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

18 This project was originally approved as
19 project 07093 in October of 2007. Currently the
20 project is obligated and the Alder project cost is
21 approximately \$82 million. This is the second
22 renewal request for this project. The requested
23 completion date is September 1st, 2012.

24 Thank you, Mr. Chairman.

1 CHAIRMAN GALASSIE: Thank you, sir. Any
2 comments for the board?

3 MS. CURTH: Yes. Good morning, Mr. Chairman
4 and members of the board and staff.

5 CHAIRMAN GALASSIE: Good morning.

6 MS. CURTH: My name is Nicolette Curth.
7 I'm the System Director for Business Development for
8 Provena Resurrection Health Care. With me this
9 morning are Bruno Giacomussi, the Vice-president for
10 Professional Services at Resurrection Medical
11 Center, and Robert Hauptman, who is our
12 Vice-president for Facilities and Construction for
13 Provena Resurrection Health Care.

14 Thank you for allowing us to come before
15 you for the second renewal of the Resurrection
16 Medical Center's patient care addition project.

17 We are before you for a second renewal
18 because unforeseen construction needs surfaced while
19 preparing the very last section of the renovation at
20 the end of the project. The project remains under
21 budget and the scope and size of the project remains
22 as approved in the original application and first
23 approved alteration.

24 I have brought the two experts on these

1 matters with me, so we are happy to entertain any
2 questions you may have.

3 CHAIRMAN GALASSIE: Thank you. Questions on
4 the part of board members?

5 MR. GREIMAN: What was the issues that you
6 found things that occurred that you didn't expect to
7 occur?

8 MR. HAUPTMAN: Yes. These were unforeseen
9 conditions that we ran into as we were in the final
10 third floor doing the remodeling and renovation. We
11 found some ductwork that was open that had to be
12 closed. We found a number of missing dampers, and
13 we also found lying ductwork which was never on any
14 drawing that we had. These are correctable items
15 that we couldn't proceed with IDPH unless we would
16 never get a final approval for the project so these
17 had to be taken care of.

18 MR. GREIMAN: Does that change the amount of
19 funding for the project?

20 MR. HAUPTMAN: No. We do have contingency
21 built in. We have not gone over our contingency and
22 it is not going to change it. It was considered in
23 case we ran into this.

24 CHAIRMAN GALASSIE: You're still under the

1 project budget?

2 MR. HAUPTMAN: We are under the project

3 budget, correct.

4 CHAIRMAN GALASSIE: Thank you.

5 MR. HAUPTMAN: Thank you.

6 CHAIRMAN GALASSIE: Other questions?

7 Hearing none, do we have a motion to approve permit

8 renewal for project 07-093, Resurrection Medical

9 Center?

10 MR. GREIMAN: So moved.

11 MR. SEWELL: Second.

12 CHAIRMAN GALASSIE: Moved and seconded.

13 MR. ROATE: Motion made by Mr. Greiman and

14 Mr. Sewell. Mr. Burden?

15 DR. BURDEN: Yes.

16 MR. ROATE: Mr. Eaker?

17 MR. EAKER: Yes.

18 MR. ROATE: Justice Greiman?

19 MR. GREIMAN: Yes.

20 MR. ROATE: Mr. Hayes?

21 MR. HAYES: Yes.

22 MR. ROATE: Mr. Hilgenbrink?

23 MR. HILGENBRINK: Yes.

24 MR. ROATE: Ms. Olson?

1 MS. OLSON: Yes.

2 MR. ROATE: Mr. Sewell?

3 MR. SEWELL: Yes.

4 MR. ROATE: Chairman Galassie?

5 CHAIRMAN GALASSIE: Yes. Motion passes.

6 Congratulations.

7 MS. CURTH: Thank you.

8 MR. HAUPTMAN: Thank you.

9 CHAIRMAN GALASSIE: Thank you. Moving to
10 item C1, Mercy Hospital and Medical Center. Change
11 of ownership.

12 Good morning, ladies and gentlemen. If
13 you would introduce yourselves and spell your names
14 to our reporter and then we will have you sworn in.

15 MR. GREENE: Edward Green on behalf of the
16 applicants.

17 SISTER LYNE: Sister Sheila Lyne, Mercy
18 Hospital.

19 MS. SZYMANSKI: Maria Szymanski, Trinity
20 Health.

21 MR. HALE: Dan Hale, Trinity health.

22 (ALL WITNESS SWORN)

23 CHAIRMAN GALASSIE: I just want to say good
24 morning and welcome to a public health colleague. I

1 almost said old colleague, but I didn't want to say
2 that in terms of we've both been in the system.

3 Staff report, Mike.

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

5 The applicants, Trinity Health Corporation
6 and Mercy Health System, are proposing a change of
7 ownership for Mercy Hospital and Medical Center.
8 The hospital will remain the licensee and operating
9 entity and owner of the site. Mercy Health System
10 will remain the sole corporate member of the
11 hospital. This project is before you today because
12 the project proposes a change of control of a health
13 care facility. No public hearing was held and no
14 letters of opposition were received. Letters of
15 support were received by the state board staff.

16 Finally, the applicants have met all the
17 requirements of the state board. Thank you,
18 Mr. Chairman.

19 CHAIRMAN GALASSIE: Thank you. Would
20 someone like to make comments to the board?

21 MS. SZYMANSKI: Yes, let me start. Good
22 morning, my name Maria Szymanski. I am the Senior
23 Vice-president and Chief Development Officer for
24 Trinity Health. With me is Dan Hale, our Executive

1 Vice-president. He heads our office of community
2 benefit and public affairs, and he is also Trinity's
3 regional representative in the State of Illinois and
4 in the Chicago land area.

5 Of course, you all know Sister Sheila
6 Lyne, who is the president of Mercy Health System,
7 as well as president and CEO of Mercy Medical
8 Centers. And, finally, Ed Green, who is our outside
9 counsel from Foley and Lardner.

10 We appear before you today seeking your
11 permission to complete a proposed transaction
12 whereby Trinity and Mercy Health System and Trinity
13 will become the sole member of Mercy Health System.
14 Because the state agency reports for the
15 transaction, contains no negative findings and
16 because there are no objections to the transaction,
17 I will be brief.

18 Trinity is the fourth largest Catholic
19 health care system in the United States. We are
20 based in Novi, Michigan. We operate 47 acute care
21 hospitals in ten states throughout the country. We
22 have 400 plus outpatient facilities, 31 long-term
23 care facilities, and numerous home health and
24 hospice programs throughout the geography that we

1 cover. We employ more than 53,000 full-time staff
2 and had 7.4 billion in operating revenue in our
3 fiscal year 2011.

4 As a not-for-profit health system, Trinity
5 invests in its communities through programs which
6 serve the poor and uninsured, managed chronic
7 conditions and help educate residents in health
8 care. In fiscal 2011 this included nearly
9 460 million in such community benefits.

10 As you will recall, we appeared before you
11 in May of 2011 when we sought your permission to
12 become the sole member of Loyola Health System.
13 That transaction was completed as of July of 2011.
14 Like the Loyola transaction, the Mercy transaction
15 allows Trinity to continue its commitment to
16 strengthening Catholic health care in Chicago. Both
17 Mercy and Trinity share an unrelenting focus on
18 excellent care, so an affiliation at this time makes
19 good sense for both organizations as well as for the
20 associates, the physicians, the patients and the
21 communities served by Mercy.

22 Importantly, as part of the transaction,
23 Trinity is also committed to cause the expenditure
24 of no less than an \$140 million to Mercy over a

1 five-year period for capital information systems and
2 equipment needs to support the operations of Mercy.

3 And, finally, on behalf of Trinity, I want
4 to thank the staff and each of you for the
5 incredibly positive experience we've had in
6 Illinois. I would like now to turn the mic over to
7 Sister Sheila who I'm sure many of you know.

8 SISTER LYNE: Thank you and good morning to
9 all of you. I'm Sister Sheila Lyne, President and
10 CEO of Mercy Hospital in Chicago. Have been that
11 for a few years.

12 Today is the culmination of our multi-year
13 effort to find the perfect partner to assist Mercy
14 in our unwavering mission to provide health care for
15 the poor and underserved in Chicago, particularly on
16 the South side of the Chicago.

17 Mercy was founded in 1852. We were the
18 first hospital in the City of Chicago and have
19 served the residents of Chicago for more than 160
20 years.

21 Trinity and Mercy share complementally
22 missions and similarities in legacy and have had
23 strong collaborative relationships for a few years.
24 Trinity has assisted Mercy with operational

1 improvements in several areas, such as supply chain
2 and information systems.

3 I would also like to note that Trinity has
4 roots with the Sister of Mercy. It was actually the
5 Sisters of Mercy in Detroit who kind of started all
6 of this. But the Sisters of Mercy started it and
7 continued it and continued to be a part of this.

8 So the missions of Trinity and Mercy are
9 aligned and the commitment to strengthening Catholic
10 health care in Chicago is passionately shared and
11 will enhance the solid blueprint of Catholic health
12 care in Chicago to the benefit of those served by
13 Mercy.

14 Indeed, Trinity intends to preserve and
15 enhance Mercy's longstanding and unwavering
16 commitment to health care in Chicago. For these
17 reasons and many others, I would ask that you
18 approve this transaction.

19 With that, we were ready to answer your
20 questions and look forward to another 160 years in
21 Chicago.

22 CHAIRMAN GALASSIE: Thank you, Sister, and
23 we wish you as well.

24 Questions from board members?

1 MR. GREIMAN: So, Sister, what percentage of
2 your activities are for charity, are based on
3 charity?

4 SISTER LYNE: Well, if you look at Medicaid,
5 we are about 44 percent of our patients are
6 Medicaid.

7 MR. GREIMAN: You have charity as well?

8 SISTER LYNE: Absolutely.

9 MR. GREIMAN: And what percentage are in
10 charity, not Medicaid?

11 SISTER LYNE: You know, I'm sorry, I don't
12 have that exact number, but it's easily in the
13 6 percent.

14 MR. GREIMAN: So my next question is to the
15 Trinity folks. In Chicago or in Illinois, what
16 percentage of your people are charity?

17 MS. SZYMANSKI: Well, at Loyola we probably
18 are around 5 percent range.

19 MR. GREIMAN: So it's your plan to continue
20 with charity as well and you have a significant size
21 Medicaid as well?

22 MS. SZYMANSKI: Absolutely, yes.

23 MR. GREIMAN: As long as you don't continue
24 to do charity work.

1 CHAIRMAN GALASSIE: Judge, I think Mike has
2 the actual numbers from the application if you would
3 like that.

4 MR. CONSTANTINO: Well, I have the 2010
5 numbers that was reported to IDPH for Mercy. Total
6 charity care expense was approximately 3.3 million
7 and Medicaid was approximately 78 million, which is
8 about 40 percent.

9 DR. BURDEN: My comments are primarily going
10 to be directed towards the Trinity group since I had
11 some personal experience in my practice career with
12 Mercy and have always labored with thought that this
13 institution must remain. It's on the south side of
14 the city and other parts of the city, you can see
15 from her proforma and the hospital profile just what
16 a safety net hospital is. 42 percent Medicaid,
17 33 percent Medicare. With what's coming down the
18 line, no one knows what Obama Care will eventually
19 bring to the table, but change is going on all
20 throughout the hospitals that you are aware of.

21 So my question is really, since I'm
22 delighted to see you here, what principles, if I may
23 quote, your scale provides greater efficiencies,
24 lower cost per unit, administrative corporate

1 services, revenue cycle, supply chain, information
2 technology. How the hell do you do that when you
3 have the setting I've just described? You tell me.
4 I'd like to hear it.

5 MS. SZYMANSKI: Well, we've been at that
6 for, I would say well over 15 years developing those
7 kind of programs. So one of the things the Sister
8 talked about is we gave her our supply chain
9 expertise and our group purchasing contract that we
10 have on a national basis. We gave that to Mercy
11 back around 2008, 2009. That program alone saves
12 Mercy, I think it's now nearly \$2 million a year in
13 regular supplies and then more than that in her
14 capital.

15 Those are programs. Since we're as large
16 as we have, we literally have departments in large
17 programs at our home office and some of them are
18 regional, so in the Chicago area we will set up
19 regional offices where we do our patient accounting
20 together.

21 We do our supply chain and our group
22 contracts together. We do some clinical things
23 together as well to get as much economies of both
24 skill and scale. So we look at the economics, but

1 we also look at the fact that by doing things
2 together we can get the best people to lead those
3 functions.

4 DR. BURDEN: Well, I'm extremely hopeful
5 that you will succeed. It's a totally different
6 challenge than my alma matter, Loyola University,
7 where Jesuits twice got out of the hospital
8 business. They're all out of it now. They
9 recognized that this was a problem. So I see this.
10 I mean, I'm not being facetious when I say that.

11 Hospital administration is a terribly
12 vexing situation. And Sister Sheila is a saint to
13 continue on, but it's been a challenge for her. I'm
14 sure she's just happy to have some economic support.

15 I'm just very hopeful that everything you
16 provide will keep everything flowing because that
17 hospital is essential for a large part of our inner
18 city, which is -- we aren't talking about a wealthy
19 suburban institution where there appears to be a
20 great deal of interest for everybody to go at large
21 and expand. This is personal. It's got nothing to
22 do with your application. It's a philosophical
23 rejoinder, so I'm happy to see your commitment.

24 CHAIRMAN GALASSIE: Just a reminder to the

1 board, if there is an interest similar to our next
2 agenda item, we can ask the the organization to come
3 back in a year or two to give us a report on the
4 status of charity care if that's something you are
5 interested in having. And if no, that's okay.

6 Any other questions?

7 MR. HAYES: In this transaction, basically
8 is there any cash changing hands?

9 MS. SZYMANSKI: There's the commitment to
10 expend 140 million in capital and there will be
11 \$40 million. That leaves Trinity's health balance
12 sheet and will go onto a fund to the Mercy Health
13 System balance sheet, yes.

14 CHAIRMAN GALASSIE: That is up front, not
15 over the five years?

16 MS. SZYMANSKI: No. That 40 million will go
17 at closing. In addition to them, the other capital
18 commitments and access to debt over the five years.

19 SISTER LYNE: And we have already figured
20 out how we're going to use it.

21 CHAIRMAN GALASSIE: I'll bet.

22 MR. HAYES: Now, this fair market value of
23 26 million, how was that calculated?

24 MS. SZYMANSKI: We looked at a business

1 enterprise value like you would normally do
2 evaluation. We looked at future cash flow and
3 looked at IBITA and looked at the risks associated
4 with that future cash flow. And as you might know,
5 we also then looked at the net financial assets of
6 Mercy, which is cash and the debts and their debt
7 situation. So in making those calculations, that is
8 where the 26 million was derived.

9 MR. HAYES: Thank you.

10 MR. HILGENBRINK: You mentioned that you
11 gave some efficiencies in the supply chain. I'd be
12 interested to know if Trinity has any positions on
13 bringing health care with their supply chain or
14 anything else that they are doing but bringing that
15 type of philosophy to you.

16 MS. SZYMANSKI: Absolutely. I don't know as
17 much about it as I probably should, but there is a
18 home office based initiative around going green, and
19 I should say the Sisters of Mercy who we've been
20 tied with, that initiative, I've done with Trinity
21 Health or one of its predecessor organizations for
22 20 years. That initiative goes back nearly the
23 entire 20.

24 The Sisters, I think, in some ways I think

1 started that movement or they certainly got on board
2 right away.

3 MR. HILGENBRINK: Thank you.

4 CHAIRMAN GALASSIE: Any other questions
5 Member Hilgenbrink?

6 MR. HILGENBRINK: No.

7 CHAIRMAN GALASSIE: Any other questions from
8 board members?

9 (No response)

10 Hearing none, may I have a motion to
11 approve the change of ownership exemption number
12 E-015-11, Mercy Hospital Medical Center of Chicago,
13 Illinois.

14 MR. SEWELL: So moved.

15 DR. BURDEN: Second.

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

18 MR. ROATE: Motion made by Mr. Sewell,
19 seconded by Dr. Burden.

20 Dr. Burden?

21 DR. BURDEN: Yes.

22 MR. ROATE: Mr. Eaker?

23 MR. EAKER: Yes.

24 MR. ROATE: Justice Greiman?

1 MR. GREIMAN: Yes.

2 MR. ROATE: Mr. Hayes?

3 MR. HAYES: Yes.

4 MR. ROATE: Mr. Hilgenbrink?

5 MR. HILGENBRINK: Yes.

6 MR. ROATE: Ms. Olson?

7 MS. OLSON: Yes.

8 MR. ROATE: Mr. Sewell?

9 MR. SEWELL: Yes.

10 MR. ROATE: Chairman Galassie?

11 CHAIRMAN GALASSIE: Yes. Motion passes,
12 congratulations.

13 Moving on to item number C-02, Rockford
14 Memorial Hospital. Rockford Memorial is coming back
15 to the board, as board members may recall, for an
16 update, the status of the merger.

17 If you would please introduce yourselves,
18 spelling your name for our reporter and then we will
19 have you gentlemen sworn in.

20 (ALL WITNESS SWORN)

21 CHAIRMAN GALASSIE: Thank you very much.
22 Staff report, Mr. Constantino.

23 MR. CONSTANTINO: Thank you, Mr. Chairman, I
24 believe you just gave it. That's all we had.

1 CHAIRMAN GALASSIE: I certainly didn't want
2 to rain on your parade.

3 MR. CONSTANTINO: That's quite all right.

4 CHAIRMAN GALASSIE: Thank you and comments
5 for the board.

6 MR. HOHULIN: Good morning. I'm Mark
7 Hohulin, Senior Vice-president of Decision Support
8 for OSF Healthcare System. With me at the table are
9 OSF's counsel, Mr. Alan Greene and Mr. Brian Hucker
10 who represents Rockford Health System and Rockford
11 Memorial Hospital. Our other representatives of our
12 system are here as well.

13 With that, I would like to turn it over to
14 Mr. Brian Hucker to provide a few other comments
15 related to this matter.

16 MR. HUCKER: Thank you.

17 Good morning. As Mark has indicated, my
18 name is Brian Hucker. I'm here on behalf of
19 Rockford Memorial Hospital as well as the Rockford
20 Health System.

21 Our purpose for appearing before you this
22 morning is threefold. First, we're here to answer
23 any questions that you may have regarding the
24 January 27 status report. It was submitted in

1 compliance with the exemption permit letter. As
2 noted in the status report, the parties are ready to
3 complete the project; however, pending FTC and
4 Federal court proceedings, make it unlikely that the
5 project can be completed prior to the May 10, 2012
6 anniversary of this permit.

7 Secondly, we are here requesting that the
8 board make a finding that the project has proceeded
9 and is proceeding with due diligence. The detail
10 for that is set out in the report and you can see
11 there's been an extensive amount of activity over
12 the last eight, ten months since we last appeared
13 before you.

14 And finally, as a result of making the
15 findings of the project is proceeding with due
16 diligence, we are here requesting that the board
17 extend the project completion date to 120 days after
18 final resolution, including appeals, pending FTC and
19 related Federal court proceedings pursuant to the
20 powers granted to the board under Section
21 1130.520V8.

22 As you may recall, the possibility that we
23 would need to appear before you for this purpose was
24 discussed at the time that the board initially

1 approve this project in May of 2012. I will just
2 add one -- I should say May 2011.

3 One addition just to note is that we
4 appear to be on track with the timeline that we
5 described for you in the January 27 letter. The
6 initial evidentiary hearing before the Federal
7 District Court Judge on a preliminary injunction
8 hearing has proceeded, but there has been no
9 decision.

10 So with that, we just thank you and we can
11 respond to any questions you may have.

12 CHAIRMAN GALASSIE: Thank you. Before I
13 open up the questions. I understand your request
14 for item number three, which would require a motion
15 on the Boards' part to extend it to, if I'm correct,
16 August 10?

17 MR. HUCKER: Well, no. We've requested that
18 the extension be open ended. You will recall last
19 year that there was some discussion with Mr. Urso
20 and staff that this possibility might come up.
21 We're asking because of the unpredictability, shall
22 we say, of the timeline here because of the pending
23 litigation, is that we would be granted 120 days
24 from the point in time of the final resolution of

1 all pending litigation and --

2 MR. URSO: Which at this time is totally
3 unknown.

4 MR. HUCKER: It is totally unknown. You
5 will recall in the status report that realistically
6 we're looking at we have potentially the end of
7 2013, depending on how far this were to proceed and
8 what happens at different stages of the proceedings.
9 Not unlike what happens in an administrative hearing
10 matter with the planning board.

11 Over the years, I'm sure Frank can attest
12 to it. I know I've been involved in cases with the
13 planning board where it has taken months, years
14 before we've gotten final resolution. It's sort of
15 similar because it's an administrative hearing and
16 also related to court proceedings.

17 CHAIRMAN GALASSIE: Thank you. I think I
18 understand that and, but I'm still not clear why you
19 would want the board to give you action recognizing
20 your due diligence on your item number two.

21 MR. HUCKER: Well, that's a function of how
22 the rule is drafted more than anything else and I
23 will read what the rule says. The rule says that an
24 exemption is valid for 12 months from the date of

1 exemption approval, and then there's a parentheses
2 that says, "(or by a later date established by the
3 HFPB upon a finding that the project has proceeded
4 with due diligence.)"

5 So just to be abundantly cautious and
6 respectful of your rules, we are suggesting or
7 requesting that a finding be made that we have
8 proceeded with due diligences and then are
9 requesting that the Board extend the date past the
10 May 10, 2012 one year.

11 CHAIRMAN GALASSIE: I appreciate that
12 clarification.

13 Mike, do you want to at least address the
14 board on the due diligence issue, are we comfortable
15 with that?

16 MR. CONSTANTINO: Yes, sir, very much so.

17 CHAIRMAN GALASSIE: Having been given that
18 clarification, at least for myself, questions on the
19 part of board members?

20 DR. BURDEN: This is a complicated issue. I
21 have no intention of trying to look at it to
22 determine what is anticompetitive and what are
23 pricing concerns, but OSF is a Catholic institution,
24 correct?

1 MR. HUCKER: That's correct.

2 DR. BURDEN: I'm just curious how that's
3 going to be handled when you do merge regarding the
4 recent mandate from Washington regarding the
5 quote/unquote, First Amendment rights versus
6 contraception, just curious. I mean, will that be
7 something that you will deal with after the merger
8 or are you going to talk about it before?

9 MR. HOHULIN: We'll have to deal with it
10 obviously beforehand, but it will be dealt with
11 throughout the process as well.

12 DR. BURDEN: I appreciate that.

13 CHAIRMAN GALASSIE: Mr. Hayes?

14 MR. HAYES: In your detailed, your letter
15 explaining what you were interested in, I think that
16 was done by a Mr. Hohulin?

17 MR. HOHULIN: That's correct.

18 MR. HAYES: Is that it goes through quite a
19 process here and explains the legal ramifications.
20 What kind of time frame are you looking at here and
21 also what are the costs associated with this
22 litigation and this due diligence process? Do you
23 have any estimate of that at all?

24 MR. HUCKER: Well, I would say this. In

1 part, because this is a public hearing, there's
2 certain strategic issues that are sensitive in terms
3 of being very specific, but the costs are
4 significant. There's no question, they're
5 significant to the taxpayers because the government
6 is pursuing this and they are significant to the
7 organizations as well and we are looking at
8 expensive, well in excess of a million dollars.

9 With that said, the organizations have
10 presented quite a bit of information to you in terms
11 of their beliefs and hopes as to the types of
12 savings that can result from this affiliation. The
13 organizations remain committed to it and they remain
14 optimistic that ultimately the courts, if not the
15 FTC, will see that this is an affiliation that will
16 benefit patients in the community, especially in the
17 changing medical environment.

18 MR. HAYES: Now, when you mention the
19 million dollars here, is that only for litigation
20 and legal fees or are you including the costs of the
21 hospital's due diligence as well as normal due
22 diligence for a transaction and the time value for a
23 transaction that -- what are you looking for, a
24 date? You gave a date of what, December 31st of

1 2013.

2 MR. HUCKER: Well, in a worst case
3 scenario -- maybe not a worst case but in a
4 realistic case scenario case were this case to
5 proceed through a complete FTC hearing, where this
6 case could then proceed through a full review by the
7 Seventh Circuit Court of Appeals, we believe that's
8 a realistic timeline.

9 There is no, as a practical matter there
10 is no ongoing due diligence as it relates to the
11 transaction per se. That was done in advance of
12 submitting the exemption request and application
13 last year. So when we're talking about due
14 diligence in this context, as distinguished from due
15 diligence in a deal context, the due diligence here
16 is that we're aggressively pursuing an effort to
17 successfully persuade the FTC and the courts, if
18 necessary, that this transaction should be allowed
19 to proceed. So it is a different kind of due
20 diligence.

21 MR. HAYES: When you're asking us to approve
22 or have a motion today, basically, is it basically
23 120 days after the FTC decides or resolves this
24 case, the litigation and everything else?

1 MR. HUCKER: Well, it goes beyond the final
2 resolution of the FTC proceeding, per se, because
3 the unsuccessful party, shall we say, if there is
4 one, and there is no settlement or something else
5 along the way, the unsuccessful party does have the
6 right to appeal an FTC decision to the Seventh
7 Circuit Court of Appeals.

8 MR. HAYES: Now, would you be open to
9 basically having another, coming back in by
10 December 31st of 2012 and be able to give another
11 report, and then basically we'll go from there, you
12 know, with another similar report of what you gave
13 today?

14 MR. HUCKER: Let me say conceptually I think
15 that we would be receptive to that. I would suggest
16 a longer date than that simply because we really
17 don't want to take up the board's time and there's
18 really the probability that we'll either be in a
19 position to complete the transaction, in which case
20 you will get a notice far in advance of that and we
21 won't need to come back at all.

22 Or, I would suggest if we were going to go
23 in that direction, that we would commit to provide
24 you with, for example, an annual status report

1 either from the original anniversary date of
2 May 2011 or from today if that's what the board
3 would prefer.

4 CHAIRMAN GALASSIE: Brian, let me piggy back
5 on Mr. Hayes' question. Recognizing the issues the
6 Board had without resolve to the FTC issue
7 previously and still exists today, what impact does
8 it have on your progress if we give you a six-month
9 extension and ask you to come back to us at that
10 point in time rather than extending this thing into
11 the 2013?

12 MR. HUCKER: I'm not sure it has an impact
13 on the case, per se. It's just a practical matter.
14 I'm not sure based on what we've projected to be the
15 the timeline that it's an efficient use of the
16 board's time or our time --

17 MR. HOHULIN: The question will be is how
18 much will we be able to progress during that time
19 period of six months. There may not be a lot of new
20 information that we can share in that amount of
21 time. We feel within a year it makes more sense, it
22 might be a little more reasonable to come back.

23 CHAIRMAN GALASSIE: I don't think we want to
24 inhibit your progress.

1 MR. HOHULIN: No, it would not.

2 CHAIRMAN GALASSIE: But I do believe the
3 Board continues to have reservation about this
4 because of the lack of resolve with the FTC.

5 MR. GREENE: As a practical matter, six
6 months from now we would be in the midst of a
7 hearing before an Administrative Law Judge in the
8 FTC case. I think more realistically, a year from
9 now we could be near the end of the process with the
10 Commissioners, if, in fact, there is an appeal
11 because we still have three stages left. We have
12 the trial before Administrative Law Judge, then we
13 have an appeal to the Commissioners themselves of
14 the Federal Trade Commission, and then, as
15 Mr. Hucker mentioned, the possibility of an appeal
16 to the Seventh Circuit Court of Appeals.

17 So while we're glad to report, we believe
18 that in six months we won't really have any
19 significant change from today that we can tell you
20 about.

21 MR. URSO: According to documents that we
22 have, if I can ask the questions, it says on
23 February 1st through the 3rd of this year, there was
24 a three-day evidentiary hearing. Did that take

1 place?

2 MR. GREENE: Yes, it did. I was there. We
3 had the full three days of evidentiary hearing. The
4 matter since, we have provided the judge in Rockford
5 with written memoranda stating our positions. The
6 matter is now fully submitted to Judge Coppola in
7 Rockford. We are awaiting a decision. He has not
8 set a ruling date, but we expect that decision to
9 come within -- very soon.

10 MR. HUCKER: But I think it's important to
11 understand in this context for everybody's benefit
12 on the board, the issue that will be determined
13 there is only a question of whether or not he will
14 issue a preliminary injunction that would stay
15 closing the transaction pending completion of the
16 FTC hearing.

17 So if he does not do that, that creates
18 certain choices for both the FTC and for the
19 parties. If he does choose to do so, then things
20 will roll out as we have described to you in the
21 letter, and as Alan has just indicated, this
22 administrative trial is scheduled to include -- the
23 evidentiary portion will be some time in late July.

24 MR. GREENE: The end of June, but the whole

1 process will not conclude until October.

2 MR. HUCKER: That's why we thought it might
3 be more practical and beneficial to everybody if we
4 didn't report back for a year.

5 Now, we have no problem with submitting
6 status reports. If the board wants us to provide
7 status reports, written status reports, we can do
8 that. But rather than having to come back and
9 request extension after extension, we thought it was
10 more practical to --

11 CHAIRMAN GALASSIE: Let me suggest this to
12 the board. Would we entertain a motion to grant an
13 extension to this project for one year from now or
14 to the completion of the FTC hearing, asking you to
15 reappear, whichever of those two dates should occur
16 first.

17 MR. HUCKER: And to be specific, so we can
18 be clear about this, when you say completion of the
19 FTC hearing, I think I could ask Alan to identify
20 which date that would be because completion means
21 different things in the way the FTC process works.

22 CHAIRMAN GALASSIE: And I don't think we're
23 looking for any dates, but spring, fall.

24 MR. GREENE: Well, we expect that the

1 administrative trial and the decision from that
2 trial will issue by mid-October of 2012. That's
3 only one stage.

4 MR. URSO: Aren't you waiting for a decision
5 from the three-day evidentiary hearing on a
6 preliminary injunction? You have no resolution of
7 that matter at this point in time, correct?

8 MR. GREENE: That is correct. But as
9 matters proceed with the Federal Trade Commission,
10 the trial before the Administrative Law Judge is set
11 to begin on April 17 no matter what.

12 It would be our hope that if, in fact, the
13 Federal Court Judge denies the preliminary
14 injunction, that the FTC would see the light of day
15 and agree that we could go forward with the
16 transaction, but realistically, we don't believe
17 that that will happen. We believe that the FTC will
18 continue to the administrative trial. So we're
19 really on two fronts at the same time.

20 MR. URSO: Do you anticipate the date when
21 you're going to receive a ruling on the preliminary
22 injunction hearing?

23 MR. GREENE: The Judge did not set a ruling
24 date. We would hope by middle of March that we will

1 have it. But that is a hope, that's not a date from
2 the judge. The Judge knows as well that we have an
3 administrative trial starting.

4 CHAIRMAN GALASSIE: Member Sewell?

5 MR. SEWELL: I was just going to move for
6 the motion that you entertained that the date would
7 be set to a year from now and it would mean, of
8 course, that if things had not been settled by then,
9 you could come back and, you know, give us a status
10 report.

11 MR. HUCKER: And we would be happy to do
12 that. I think what we provided the last time was
13 that the extension -- so the extension would be to
14 February 28, 2012 -- I'm sorry, 2013. And that we
15 would report back to the board, at least 30 days,
16 report in writing at least 30 days in advance of
17 that anniversary date.

18 MR. URSO: I want to make sure that the
19 board understands that this is an exemption for a
20 change of ownership and, according to the Board's
21 rules, that has been to be completed within 12
22 months unless the project is proceeding in due
23 diligence and the Board makes a determination on
24 that fact.

1 Now, Counsel, if I understood Mr. Hucker
2 correctly, he is saying they are proceeding in due
3 diligence, but the due diligence he's talking about
4 is due diligence in litigation that they are having
5 with the FTC. It is not due diligence in terms of
6 moving this project and this merger forward at this
7 point in time because they are in kind of a Catch
8 22, so to speak.

9 The FTC is not involved in the project so
10 the actual project it is not moving forward with due
11 diligence. The FTC litigation is moving forward.

12 And so I want to make sure that this Board
13 understands that distinction.

14 MR. SEWELL: But, Frank, doesn't this motion
15 though have a time frame that is within the year so
16 the issue of due diligence doesn't have to be
17 established since it's no more than a year from now.

18 MR. URSO: But see, what we have to
19 understand, I think, is that this project was
20 approved in May of 2011. So that one year clock
21 started May of 2011. So by May of 2012 it is
22 expected that this project would be completed
23 unless, and that contingency language comes into
24 play then.

1 MR. HUCKER: Frank, if I may address this
2 again to try to reiterate. Our view would differ
3 only in this sense. We believe we are proceeding
4 with all due diligence. And the only impediment to
5 closing this transaction at this point is the
6 litigation. The parties are pursuing as quickly and
7 aggressively as they can, the resolution of that
8 litigation in one form or another. So with all due
9 respect, I believe that we are proceeding with due
10 diligence in the situation we find ourselves at this
11 point. Otherwise, we are ready to go.

12 CHAIRMAN GALASSIE: So we would find our
13 motion to include and in recognition that this
14 organization is proceeding with due diligence with
15 regard to bringing resolve to litigation and that
16 the Board is granting a one-year extension to this
17 project. That's Member Sewell's motion. Is there a
18 second?

19 MR. EAKER: Second.

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

22 Dr. Burden?

23 DR. BURDEN: Yes.

24 MR. HILGENBRINK: I'm sorry, I have a

1 question. Is that one year, is that one year to
2 February or to the May date then?

3 CHAIRMAN GALASSIE: It is February. The
4 motion is February, going to amend it to May, but
5 right now the motion is February.

6 MR. HILGENBRINK: You're saying February of
7 2013?

8 CHAIRMAN GALASSIE: Yes. 2013. Back to the
9 roll call, please.

10 MR. ROATE: Dr. Burden voted yes.
11 Mr. Eaker?

12 MR. EAKER: Yes.

13 MR. ROATE: Justice Greiman?

14 MR. GREIMAN: Yes.

15 MR. ROATE: Mr. Hayes?

16 MR. HAYES: Yes.

17 MR. ROATE: Mr. Hilgenbrink?

18 MR. HILGENBRINK: Yes.

19 MR. ROATE: Ms. Olson?

20 MS. OLSON: Abstain.

21 MR. ROATE: Mr. Sewell?

22 MR. SEWELL: Yes.

23 MR. ROATE: Chairman Galassie?

24 CHAIRMAN GALASSIE: Yes.

1 MR. ROATE: That's seven votes in the
2 affirmative, one abstinence.

3 CHAIRMAN GALASSIE: Motion passes.

4 MR. HUCKER: Thank you, Mr. Chairman, and as
5 we did the last time, I assume the permit letter
6 will provide that we are to report back on the
7 status of this project at least 30 days in advance
8 of that deadline and that we may again submit a
9 request for further extension if we need to.

10 CHAIRMAN GALASSIE: Correct.

11 MR. HUCKER: Thank you very much.

12 CHAIRMAN GALASSIE: Thank you.

13 Moving on to items on the agenda, item D,
14 alteration requests, we have none. Item E,
15 declaratory ruling or other business, we have none.
16 Item F, healthcare worker self referrals, we have
17 none. Item J, status report on conditional or
18 contingent permits, we have none.

19 We are moving into item H, applicants
20 subsequent to initial review. Just so people
21 understand, I intend to go about another half hour,
22 take a break. We will then proceed until 12:30 when
23 the Board will be breaking for about 45 minutes for
24 lunch.

1 Item H1, St. Joseph's Hospital. If you
2 will please come up to the table and introduce
3 yourselves by spelling your names to our reporter.
4 I'm sorry, I apologize.

5 We're going to read guidelines for public
6 comment. We will then call people up about three at
7 a time for public comment. How many public comment
8 requests do we have on this item?

9 MR. MORADO: Five total.

10 CHAIRMAN GALASSIE: All five in support.
11 Very good. If you would give us the guidelines.

12 MR. MORADO: The open meeting requires that
13 any person shall be permitted an opportunity to
14 address public officials under the rules established
15 and recorded by the public body. Following is the
16 procedure which the Illinois Health Facilities and
17 Services Review Board will adhere to.

18 If you have previously participated in any
19 public hearings or submitted comments related to
20 projects listed on today's agenda, you will not be
21 allowed to repeat your comments because each board
22 member has already received those materials. Board
23 staff will be comparing the speaker's public hearing
24 testimony and/or previously written comments to

1 assure that the public participation testimony is
2 not repetitive. Speakers will be reminded not to
3 provide repetitive comments.

4 So that the Board is able to accomplish
5 other agenda items, each speaker will be allotted a
6 maximum of two minutes to provide their comments.
7 Please understand that when Chairman signals, you
8 must conclude your comments.

9 Inflammatory or derogatory comments are
10 prohibited. No more than three persons representing
11 the same organization are allowed to provide
12 testimony regarding the same project.

13 Public comments for each speaker is
14 limited to testimony for one project or issue. The
15 Board asks that you please make sure that all
16 comments are focused and relevant to the specific
17 projects on the current agenda. Comments should not
18 be repetitive and not be disruptive to the Board's
19 proceedings.

20 The public is strongly urged to
21 participate in longstanding opportunities for oral
22 and written comments provided by the public hearings
23 conducted where CON project under review.

24 Scheduled public hearings are posted on

1 the Health Facilities and Services Review Board web
2 site.

3 Speakers who do not comply with these
4 guidelines will not be allowed to provide comments
5 at the Board's open meeting. And please note for
6 the future that, anyone wanting to provide public
7 participation comments at a board meeting, must
8 preregister. The only time to preregister will
9 begin 30 minutes before the scheduled board
10 meetings.

11 CHAIRMAN GALASSIE: So if you haven't signed
12 up, it's too late.

13 Juan, thank you very much.

14 We will now call three of the five for the
15 table -- why don't you just call all five names and
16 then we'll cycle as people come up. We do not have
17 a lot of public hearing requests. We do appreciate
18 your compliance with our guidelines, thank you.

19 MR. MORADO: Bill Sullivan, Wayne Steiner,
20 Reverend Charles A. Edwards and Mark Latham. We
21 also had another form filled out, but it was signed
22 St. Joseph's Hospital, so I'm not sure who that
23 individual is.

24 MR. HILL: Tom Hill.

1 MR. MORADO: That person can come up as
2 well. Tom.

3 CHAIRMAN GALASSIE: Good morning, gentlemen.
4 Since this is public comment you do not have been
5 sworn in. I would ask, we'll start close to the
6 recorder there, if you will introduce yourself and
7 spell your name for our recorder, and then give your
8 public comment.

9 MR. HILL: My name is Thomas Hill. I am the
10 Co-chairman for St. Joseph's Hospital. H-I-L-L.

11 Good morning. I appreciate the
12 opportunity to address the board this morning.
13 St. Joseph's Hospital has been a major contributor
14 to the success of the Highland community. Both
15 state and Federal governments having recognized the
16 need for a local hospital in Highland, having
17 designated St. Joseph's Hospital as its critical
18 access hospital. We need to build on that success,
19 but a replacement hospital that would better serve
20 the needs of Highland and the adjoining rural
21 communities. Highland is a commercial center for
22 the rural part of eastern Madison County and parts
23 of adjoining counties. They boast a strong
24 agricultural base, several manufacturing facilities

1 that complement its many commercial establishments.

2 Even though located in the southeastern
3 part of Madison County, Highland public and
4 parochial schools draw students from all of rural
5 eastern Madison County and parts of Bond County.
6 Highland hosts the Madison County Fair, testifying
7 to its close ties with the farming community.
8 Highland enjoys population growth, low employment.

9 Several residential facilities for seniors
10 and nursing homes complement its numerous other
11 community assets. Citizens need a safe, quality,
12 convenient modern hospital to meet their healthcare
13 needs. Our planned replacement St. Joseph's
14 Hospital will definitely do so.

15 The existing St. Joseph's Hospital was
16 built for another time. Modern technology, though
17 available, is not conveniently accessed by patients,
18 particularly outpatients and the elderly. For
19 example, patients must walk out of doors and
20 upstairs to obtain MRI tests. Ambulances arriving
21 from nursing homes or accident sites are too large
22 to enter any covered unloading area. The
23 infrastructure of the hospital needs wholesale
24 replacement, parking is in short supply, but the

1 facility is land locked making expansion at its
2 current location prohibitively expensive and
3 practically unfeasible. In short, the facility
4 needs replacement.

5 Highland community wholeheartedly supports
6 our efforts to replace St. Joseph's Hospital. We
7 ask your approval so that Highlanders can enjoy the
8 21st century healthcare services they deserve.

9 CHAIRMAN GALASSIE: Thank you, Chairman
10 Hill.

11 REVEREND EDWARDS: I'm Reverend Charles
12 Edwards, Pastor of St. Joseph's in Highland.

13 I thank you for the opportunity to speak
14 on behalf of St. Joseph's Hospital in Highland. I'm
15 currently pastor of St. Paul's Parish across the
16 street from St. Joseph's. Our parish began the
17 hospital in Highland in 1879. In the Franciscan
18 tradition, St. Joseph Hospital has offered and still
19 serves the Highland area with a superb quality faith
20 based compassionate health care system now for over
21 100 years.

22 First built on the edge of town, it is now
23 located in the middle of our Highland community in
24 an area intersection which is probably the most well

1 driven area of our town of 10,000. Well known for
2 being the great health care center and spoken of as
3 being one of the cleanest, yet oldest hospitals in
4 the 100-mile area. Folks in this area have depended
5 on this excellent health care facility and feel
6 uniquely blessed with its presence in our community.
7 Now in 2012, the need to relocate and update the
8 facility is so necessary to be most effective for
9 health care service and ministry to our people.

10 I'm sure you already have heard of the
11 HSHA Franciscan Sisters Health Care System based in
12 our state's capital. These religious women have
13 given health care to millions in the
14 Illinois/Wisconsin area for over 150 years. They
15 know what they're doing and their community and many
16 others like Highland feel very blessed.

17 St. Francis was the one who taught the
18 need to care for the poor. St. Francis, hundreds of
19 our folks who have great health care needs, but may
20 not have the resources, depend upon this hospital
21 and its mission to help the poor and care for their
22 needs for physical and mental and spiritual health.

23 I thank you for your work to help
24 guarantee quality health care for the State of

1 Illinois. I believe you can be proud of this
2 hospital for embracing your vision of health care
3 for Southern Illinois. We need and believe that
4 this new facility will take us into an even greater
5 quality, greater effectiveness and greater
6 compassionate care to our folks for 100 years to
7 come.

8 Thank you and God bless you for your
9 consideration of our plan.

10 CHAIRMAN GALASSIE: Thank you, Reverend.

11 MR. LATHAM: My name is Mark Latham.
12 L-A-T-H-A-M. I'm currently the City Manager for the
13 City of Highland.

14 In 2005, the city embarked on a vision to
15 create the the best small town in Southern Illinois.
16 Through its strategic plan, it identified the needs
17 for replacement health care. The commitment was
18 made by HSHS to build a temporary replacement
19 hospital. It is critical to the overall economic
20 stability and thriving growth the community is
21 seeking for its future.

22 It was determined that, in order for the
23 city to successfully accomplish its goals as a
24 community of well being, it is important that we

1 achieve improved health care, job creation, topnotch
2 education and a high level of public safety.

3 Currently the City of Highland has an
4 outstanding school system, very low crime rate, a
5 job creation program which focuses on
6 entrepreneurship and now we have the opportunity for
7 a new contemporary replacement hospital.

8 Local public officials including the mayor
9 and the city council have committed over \$10 million
10 for infrastructure improvements to insure this
11 facility is served with adequate roads and
12 utilities. And I am certain that a state of the art
13 replacement hospital is a key, not only to providing
14 the growing medical needs of our citizens but the
15 economic growth vital to our community as well.

16 I respectfully request that this board
17 approve the certificate of need to replacement
18 hospital which ultimately benefits all the citizens
19 of the City of Highland and surrounding area. Thank
20 you for your consideration.

21 CHAIRMAN GALASSIE: Thank you, Manager
22 Latham.

23 MR. SULLIVAN: Good morning. My name is
24 Bill Sullivan, S-U-L-L-I-V-A-N. I am the

1 Vice-chairman of the St. Joseph's Board of Directors
2 and I also happen to be a business owner in
3 Highland. I own a manufacturing facility.

4 My facility was built in 1940, so I sort
5 of have a feel for working in aging facilities. I
6 know the difficulties when you're trying to upgrade
7 to new technology. I've had to rip out walls to
8 bring in new equipment. I've had to dig up floors.
9 I've had to bypass equipment because my ceilings
10 weren't tall enough, so I know what happens when
11 you're working in a facility that is not up to date
12 and works well with the times.

13 We can't stay current necessarily with all
14 forms of technology. There's all kinds of
15 inefficiencies built in to aging facilities. We may
16 have to locate a piece of equipment on another side
17 of the building rather than where I want it, and as
18 a result, I'm picking up a product time and time
19 again and moving it and moving it and every time I
20 do that it costs us money. So the question is why
21 would I talk about that when we're here to talk
22 about St. Joe's Hospital.

23 This hospital is very much like my
24 business. It is facing the same problems that I

1 face in running my business every day. It is facing
2 the same problems in trying to remain competitive
3 and stay up with the times.

4 The hospital has x-ray departments located
5 four or five different places. When we take
6 somebody out for an MRI, we have to take them out of
7 the building into a truck. When somebody is in
8 surgery and then needs x-rays, before the surgery
9 can continue, we take them down in an elevator over.
10 It's not efficient. Every time we move a patient,
11 we become less efficient and that costs us money.
12 And the last thing we need to be doing right now is
13 costing the hospital money in a time when we are
14 supposed to be saving money and being more
15 efficient.

16 So I'm asking your support for this
17 project. We need to be able to expand this hospital
18 to get a better campus to work on. We need to be
19 able to expand our parking so that our patients can
20 get into the building safely without having to cross
21 busy streets of traffic. We need a better
22 infrastructure so we can put that MRI in the
23 hospital with all of the other radiology equipment,
24 not in three or four or five different places of the

1 hospital. We need to be efficient.

2 MR. MORADO: Conclude your comments.

3 MR. SULLIVAN: Just like I said, I do ask
4 your support. We need to become more efficient. As
5 a business owner I recognize this need and I thank
6 you for your support.

7 CHAIRMAN GALASSIE: Thank you, Mr. Sullivan.

8 MR. STEINER: Thank you for the opportunity
9 to address this board today. My name is Wayne
10 Steiner. S-T-E-I-N-E-R. I serve as the chairperson
11 for the Friends of St. Joseph's Hospital Highland
12 board. The Friends Board serves as a liaison to the
13 local community. We help fundraise for St. Joseph's
14 Hospital. We provide input to hospital management.
15 We help spread the good news about the hospital to
16 the community and, of course, we are involved with
17 the project to replace our existing hospital.

18 Our board consists of 15 community members
19 from all areas, business men and women, retired
20 individuals, homemakers and others.

21 About two years ago when the project
22 started to evolve, it became clear that we as a
23 board needed to involve the community in as much of
24 the project as possible. We started to recruit

1 individuals to help us with various aspects of the
2 project. We set up committees to help with the
3 capital campaign.

4 The community wants to be involved. The
5 community wants to see the hospital built. The
6 community wants to know that they have made a
7 difference for future generations.

8 We have made presentations, have helped
9 create awareness, answered questions, given the
10 community an overview, and that has led many to ask
11 when are you going to build and open. Again, very
12 simply, the community wants this.

13 I'm quite confident that there are others
14 here today that will speak eloquently to the need of
15 the replacement hospital in our rural community. To
16 the economic impact of the replacement hospital. To
17 the design of the replacement hospital. That's not
18 why I'm here. I'm here to assure you that the
19 community is behind this project fully.

20 The hospital system started caring for
21 patients over 130 years ago in Highland, Illinois.
22 It is our hope and dream that the care provided in
23 the past and today can continue into the future.
24 Please help us provide that care and fulfill that

1 dream for my children, their children and the many
2 generations yet to come. Thank you.

3 CHAIRMAN GALASSIE: Thank you, Mr. Steiner.
4 Gentlemen, thank you. And now if the folks from
5 St. Joseph's Hospital could come to the table and
6 introduce yourselves, again spelling your names
7 please for our reporter and then be sworn in.

8 (ALL WITNESSES SWORN)

9 CHAIRMAN GALASSIE: Thank you. Good
10 morning.

11 Mike, could we have a staff report,
12 please.

13 MR. CONSTANTINO: Thank you, Mr. Chairman.
14 The applicants are proposing the discontinuation and
15 the replacement of a critical access hospital in
16 Highland, Illinois. The cost of the project is
17 approximately \$47.3 million. The applicants are
18 before you today because they are proposing a
19 discontinuation in the establishment of a health
20 care facility.

21 The state board staff would like to know
22 if there was no public hearing and no letters of
23 opposition were received by the state board staff.
24 Twenty-three letters of support were received.

1 Secondly, this hospital has been deemed a
2 necessary provider by the State of Illinois because
3 of its rural location.

4 Finally, this hospital is also proposing
5 to utilize their medical surgical beds for long-term
6 care, which is a swing bed program.

7 Thank you, Mr. Chairman.

8 CHAIRMAN GALASSIE: Thank you. Good
9 morning. You had some very articulate and eloquent
10 speakers in your support and in your presentation to
11 the Board I would just remind you that there is no
12 opposition to this project, which is certainly to
13 your benefit.

14 Would someone like to address the board?

15 MS. SEBASTIAN: Yes, sir, I would. Thank
16 you.

17 Good morning, I'm Peggy Sebastian. I
18 serve as President and CEO and St. Joseph's
19 Hospital. With me today is Dennis Hutchenson.
20 Dennis is the Director of Business Development
21 Sommer Perry is a member of the strategy team from
22 HSHS, and then Johnny Watkins is the Chief Financial
23 Officer for the Southern Division for Hospital of
24 Sisters.

1 We are pleased to be here today to discuss
2 our project to replace our critical access hospital
3 on the the location slightly more than a mile from
4 our current location. We appreciate the staff's
5 meaningful and insightful review of our application
6 citing support for our need and scope.

7 Our new campus will be located in the same
8 municipality, in the same planning area as its
9 predecessor and all the facilities that we have had
10 for the last 134 years. St. Joseph's was founded by
11 Hospital Sisters in 1878 and the Sisters initially
12 provided care in homes, as you heard, built small
13 hospitals in rural communities. Under the Hospital
14 Sisters' sponsorship, this system now is known is
15 Hospital Sisters Health System, sponsors eight
16 hospitals in Illinois and five hospitals up in
17 Wisconsin.

18 The public comment that we heard, we see
19 that the project from our local community and public
20 officials shows evidence of the support for the two
21 projects that you are considering today, the
22 construction replacement of our existing facility
23 and then the leasing of space for the outpatient
24 administrative services in adjacent medical office

1 building or MOB that will be owned and operated by
2 an unrelated third-party developer.

3 The MOB is a separate CON application
4 that's next project on your agenda. The project
5 that you are considering right now is to replace our
6 hospital. Our hospital building much of which is 63
7 years old needs to be replaced. We are pleased that
8 the staff concludes that it is appropriate to
9 replace our old facility with a new one.
10 Replacement hospital will continue to be designated
11 as a critical access hospital and will meet
12 contemporary standards with private patient rooms,
13 electrical mechanical systems, clinical services
14 that are designed to accommodate technological
15 equipment in the treatment of larger outpatient
16 caseloads.

17 The placement of the existing hospital is
18 predicated on how we continue to treat our current
19 caseload and accommodating an increasing and aging
20 population within our hospital's current service
21 area.

22 Our project will show a utilization that
23 justifies the 25 med-surge beds. It also, as
24 discussed, please consider that we have been

1 designated by the Federal government and the
2 Illinois Department of Public Health as a necessary
3 provider of health services authorized by the
4 Illinois rural health plan and also the the Federal
5 Critical Access Program.

6 Our hospital is located in Highland, which
7 is identified as a rural area. Our market is a
8 large proportion of elderly residents and our
9 population is aging rapidly. The majority of our
10 patients that are served are in a federally
11 designated health professional shortage area, which
12 means that we're short on primary care providers.

13 The design and scope of our project was a
14 result of a lengthy and deliberative process which
15 we considered several alternatives. We looked at
16 modernization, expansion, and then replacement of
17 the existing hospital on the existing campus.

18 The project that we have pursued is the
19 most cost effective solution for correcting the
20 constraints and inefficiencies of our current
21 facility and providing patients with the appropriate
22 care in an up-to-date facility.

23 We'd like to take a few minutes to respond
24 to the only negative finding that we received from

1 the state agent's report and that's the proposed
2 square footage from our recovery room or what we
3 nurses would call it, the PACU.

4 The negative findings due to the fact that
5 we have three stations for recovery are post
6 anesthesia care. This will exceed the state's
7 square footage standard for this department by a
8 total of 378 square feet. Please note that this is
9 the only department in the hospital that exceeds the
10 standards and that all other departments in the
11 project meets standards.

12 In designing or replacement of critical
13 access hospitals, we knew that the square footage
14 for PACU would exceed the state standard and we've
15 provided a detailed justification of this in our CON
16 application, you can find those on pages 223 to 225.

17 First, a PACU is required in the Illinois
18 hospital licensing to have certain fixed elements,
19 so you have to have a nurses station, you have to
20 have toilet room, you have to soil and utility in
21 certain circulating space. When you divide that
22 across only three PACU stations as opposed to a
23 facility that has larger number of stations, the
24 square feet per station then on per case is higher

1 than would be for someone that had more, and
2 typically hospitals have larger numbers than three.

3 The second is our PACU will have an
4 isolation recovery cubicle with ante room and also
5 patient toilet. The isolation recovery cubicle will
6 be larger than the routine PACU station because it
7 has walls as opposed to curtains.

8 And then finally, the rules, our rule was
9 adopted in 2011 by the hospital licensing
10 requirements that said that we must permit visitors,
11 and, so in order to accommodate a chair in the same
12 space with the curtain, then it also was harder to
13 accommodate this larger number of space. Thus, so
14 it would be impossible for us to accommodate the
15 required support plus the isolation space within the
16 square footage standards that most hospitals would
17 have that have more than three stations.

18 I would like to note though that the
19 combination of the PACU and then what's known as the
20 second stage recovery, which is required if you do
21 outpatient surgery, that those two areas combined is
22 less than the state standard and is less than the
23 state standard by 898 square feet combined.

24 In closing I would like to say that we

1 are a not-for-profit mission-driven hospital. We
2 take our mission very seriously. You heard from
3 several board members, management, employees and
4 physicians, all who take very seriously and are good
5 stewards of our tremendous resource that we have in
6 our community. Funds have already been raised
7 through Our Friends of St. Joseph Foundation and
8 have been committed to this project. It's noted in
9 our CON and also in our staff report.

10 Additionally, we are currently involved in
11 a capital campaign to fundraise additional funds for
12 our project.

13 Our hospital efforts to serve the
14 uninsured and the underinsured includes the Hospital
15 Sisters Health Systems Charity Care Policy and then
16 a treatment of high percentage of Medicare.

17 In summary, the Hospital Sisters have been
18 devoted to our mission to serve our community health
19 care needs for the past 134 years. With this
20 replacement hospital we'll serve our community for
21 generations to come. Thank you and I appreciate
22 being able to address you today and I'm open if you
23 have any questions.

24 CHAIRMAN GALASSIE: Thank you very much. We

1 appreciate your presentation.

2 Are there any questions from the board?

3 DR. BURDEN: I have a question.

4 CHAIRMAN GALASSIE: Dr. Burden.

5 DR. BURDEN: I'm just aware, of course, that
6 the critical access hospital has the unique position
7 and the applicants that we see, however, we are
8 obligated to review this critical access hospital in
9 a manner that takes into consideration that there
10 are certain in excess of med-surge beds in the area.
11 I want to ask a few questions which I think I have
12 here. What is the population of Highland?

13 MS. SEBASTIAN: Highland is a community of
14 10,000 people.

15 DR. BURDEN: And you said there is a
16 shortage of primary care doctors. I'm asking a
17 question, as a physician, I see there's no
18 obstetrics --

19 MS. SEBASTIAN: That is correct.

20 DR. BURDEN: Is that because you can't get
21 an obstetrician or how far does a woman who is
22 pregnant and in labor have to go have to get a board
23 certified obstetrician?

24 MS. SEBASTIAN: 17 miles. Our sister

1 hospital is 17 miles away that has an obstetrics
2 department. That's the closest.

3 DR. BURDEN: What's that hospital, I don't
4 see it on here.

5 MS. SEBASTIAN: St. Joseph Hospital, Breese,
6 Illinois.

7 DR. BURDEN: That's how long of a period of
8 time does that take?

9 MS. SEBASTIAN: It takes about 15 to 17
10 minutes.

11 DR. BURDEN: I'm always a little concerned
12 about that and I'll tell you why. Before I got
13 appointed to this board, I served for 15 years on an
14 institution called the Illinois State Medical
15 Insurance Exchange, and we had many defense
16 attorneys just sweating bullets when they had a case
17 in Madison County, St. Clair County. I can talk
18 anecdotally about our attorneys riding up in a
19 rented Civic and the others driving up in a
20 chauffeur-driven Rolls Royce, so I'm looking at a
21 situation here that there will be a very high rate
22 of insurance claims and costs and I'm not saying you
23 got to change your modus operandi. Obviously, you
24 feel it's working. But I look at this and I say

1 okay, we're going to vote for this, we're going to
2 and discuss it, I'm looking at it from two hats, as
3 a practicing physician for 40 years and also the
4 liability. How many primary care doctors do you
5 have on board?

6 MS. SEBASTIAN: We currently have seven
7 primary care physicians and then there are also five
8 advance practice clinicians, nurse practitioners and
9 PAs in our community.

10 DR. BURDEN: Are these seven salaried or are
11 they dependent on the institution?

12 MS. SEBASTIAN: We have an associate
13 organization called the HSHS Medical Group and so
14 the medical group does employ primary care
15 providers, so some of them are employed, then we
16 also have some independent physicians.

17 DR. BURDEN: If you're looking forward to
18 the government okaying Obama Care, you're going to
19 find funds to be a little shy to take care of some
20 of things you're talking about, which I suppose has
21 a lot to do why you're here today. But I know as a
22 physician, I'm concerned about that.

23 Well, I'm looking at one last thing and
24 then I'll shut up. I'm sure that you'll be anxious

1 to hear that.

2 I'm looking at your hospital file and I
3 don't have to ask you about the community. 1.2
4 Medicaid. And 98 percent Caucasian. You were here
5 to listen to an application that came from the City
6 of Chicago where it was 42 percent Medicaid, and I
7 can tell you the demographics of that is not
8 Caucasian. People who are poor who have a problem
9 with getting adequate medical care. So these are
10 farmers and you have working poor white people, this
11 is a rural community, over half your hospital
12 admissions are all people in the Medicare age, all
13 over 65.

14 MS. SEBASTIAN: Yes. Our inpatient is
15 75 percent Medicare.

16 DR. BURDEN: 75 percent Medicare. Lastly,
17 the procedures that are done, you have five
18 operating rooms and whoever filled out this Table 6,
19 Projected Services Utilization was really oriented
20 to saying yes to everything.

21 We look at the actual facts besides the
22 yes. Fifteen hours per room for the two surgical
23 rooms, that comes out to 3,000 hours and yet your
24 census from last year contradicts that. You only

1 had total hours of five operating rooms, including a
2 urology room, whatever that is. As a retired
3 urologist, I would be curious. But there's a
4 disconnect bigtime, so I really want to know which
5 is factual. Was that a mistake in there, you're not
6 using your operating rooms anywhere near or is your
7 ER as busy as described?

8 I'm not saying this is wrong, but it is
9 wrong in my book if I'm to believe this data, it
10 doesn't jive, it doesn't make sense.

11 MS. SEBASTIAN: We actually do have
12 available to the surgeons five different operating
13 rooms, but there really are three operating rooms
14 that we use on a regular basis. And those hours
15 reflect that. Yes, we have an old room, but we
16 pulled out the fixed equipment out of that room
17 years ago.

18 DR. BURDEN: Do you have a plumber that
19 rotates in periodically? That's all right, that's
20 fine.

21 MS. SEBASTIAN: And our emergency room
22 department has been very stable and actually growing
23 in volume.

24 DR. BURDEN: Thank you.

1 CHAIRMAN GALASSIE: Board Member Sewell.

2 MR. SEWELL: I guess I want to ask the staff
3 a question about the size of the project, the square
4 footage in the recovery. The licensure standard
5 changed last year where visitors would be allowed.
6 Did that force any talk of reconsidering our stance
7 for size?

8 MR. CONSTANTINO: Yes. We have talked about
9 looking at our limited requirements, but we haven't
10 done anything yet to coincide with the changes made
11 at IDPH, you're correct.

12 MR. SEWELL: But we do agree among people
13 who know more about this stuff than I do that
14 allowing visitors would force the issue of perhaps
15 allowing more size for the recovery.

16 MR. CONSTANTINO: That's correct.

17 MS. OLSON: I have a couple of questions.
18 I'm interested in, part of the application asks for
19 discontinuation of Peds and ICU, but then the
20 application says you're going to provide those
21 services. Can you explain how you're going to --

22 MS. SEBASTIAN: Sure. We felt it would be
23 more flexible for us to have all med-surge beds that
24 continue to serve that population. So we seek to

1 decrease our beds and discontinue those services,
2 but continue to serve intensive-care type patients
3 or pediatric patients in the general med-surge. It
4 gives us more flexibility as opposed to when the
5 med-surge beds are filled now and our choice is to
6 float into the IC which is inefficient.

7 MS. OLSON: So they'll be kind of swing
8 meds.

9 MS. SEBASTIAN: It will be the general acute
10 med-surge beds that pediatrics would go into the
11 intensive care unit patients, and we have a special
12 designated location.

13 MS. OLSON: And my other question is, this
14 is probably doesn't have anything to do with the
15 application, but what are the plans for the existing
16 site. It seems that it is at a great intersection.
17 Are you going to demolish it and sell the property?

18 MS. SEBASTIAN: We're in the midst of that
19 study, we haven't finalized that study, but under
20 consideration is potential of demolition, potential
21 of sale as-is, the potential donation as-is or the
22 potential of either or of taking the building down.
23 But it is on a small little 4-acre piece and it's in
24 a very nice location.

1 MS. OLSON: And if I could make a comment, I
2 do live in a rural area and I do understand the
3 value of a community hospital. I think this is a
4 good project.

5 MS. SEBASTIAN: Thank you.

6 CHAIRMAN GALASSIE: Thank you, Member Olson.
7 Member Hilgenbrink?

8 MR. HILGENBRINK: Yes. I noticed in your
9 fees for consulting fees, we don't have a standard
10 for that, but they are over \$2 million. Could you
11 explain why the consulting fee, that seems high to
12 me, that is almost twice your architectural fee.
13 What gets put in that classification?

14 MS. SEBASTIAN: I might need help from state
15 staff because they define what goes into that
16 category, but so the consulting fees would include
17 when we looked at land and then we had to do
18 environmental assessments of that land so the cost
19 of the consultants to provide the environmental
20 assessment at that time and also then the soft costs
21 of legal fees and the planning fees that we had to
22 put together.

23 MR. CONSTANTINO: That's generally what we
24 see in consulting costs, CON consulting costs, but

1 that is generally what we do see. They are required
2 to provide us a complete breakdown in the
3 application of their costs per line item, and they
4 did that.

5 MR. HILGENBRINK: Kind of a follow-up
6 question. You've cited a lot of 21st century health
7 care and taking advantage of the new technologies.
8 Are you planning to have this building certified by
9 LEED or any green health compare certification?

10 MS. SEBASTIAN: We explored the use of green
11 is what he's asking, if we would pursue green, and
12 we have brought those principles forward right from
13 the beginning of our planning process to our design
14 development, schematic design. We didn't think a
15 prudent use of money to actually apply for those
16 processes to have a certificate to hang on the wall.
17 But in today's standards, much of the materials that
18 we are using are certified and are approved as
19 green.

20 CHAIRMAN GALASSIE: Thank you.

21 MR. EAKER: One more question. Table 4, the
22 Medicaid members from 2008 to 2010 plummeted. Any
23 explanation as to why those numbers?

24 MS. SEBASTIAN: Yes. I'll begin kind of

1 doing an overview and then Johnny Watkins is
2 available, our Chief Financial Officer.

3 Yes, in 2009, right before I joined the
4 organization, there was a loss of five positions
5 over that about maybe an eight-month period from
6 about May to December, and so the loss of access to
7 primary care and access then for the little bit of
8 Medicaid that we do have decreased.

9 So we quickly responded and developed
10 what's known today as Highland Priority Care and
11 it's a walk-in clinic that's open from 7:00 a.m. to
12 7:00 p.m. seven days a week. And so we made that
13 operational in November of that year. So we quickly
14 got a place for those patients to go to because
15 there just wasn't a lot of access. The independent
16 physicians in the community had capped their
17 Medicaid patients, which is not an unusual thing
18 back in that time.

19 And so, then in the following year, the
20 HSHS Medical Group assumed the operations. We
21 believe that our medical group operates clinics
22 better than we as hospitals, so we transferred that
23 clinic and it's still operational today, seven days
24 a week, 12 hours a day. We transferred that project

1 and that clinic over to the HSHS Medical Group and
2 so then it's not in our statistics any longer.

3 MR. EAKER: So Medicaid patients, rather
4 than being inpatients are basically being treated
5 outpatient then?

6 MS. SEBASTIAN: Still active to inpatient,
7 but really our utilization on the inpatient really
8 shows our demographics of our community. So we
9 still have access both inpatient and outpatient.

10 CHAIRMAN GALASSIE: I'm going to move this
11 forward to a vote. May I have a motion to approve
12 Project Number 11-015 to discontinue and establish a
13 25-bed clinical access hospital in Highland,
14 Illinois.

15 MR. HILGENBRINK: So moved.

16 DR. BURDEN: Second.

17 CHAIRMAN GALASSIE: Moved and seconded.

18 Roll, please.

19 MR. ROATE: Moved by Mr. Hilgenbrink,
20 seconded by Dr. Burden.

21 Dr. Burden?

22 DR. BURDEN: Yes.

23 MR. ROATE: Mr. Eaker?

24 MR. EAKER: Yes.

1 MR. ROATE: Judge Greiman?
2 MR. GREIMAN: Yes.
3 MR. ROATE: Mr. Hayes?
4 MR. HAYES: Yes.
5 MR. ROATE: Mr. Hilgenbrink?
6 MR. HILGENBRINK: Yes.
7 MR. ROATE: Ms. Olson?
8 MS. OLSON: Yes.
9 MR. ROATE: Mr. Sewell?
10 MR. SEWELL: No.
11 MR. ROATE: Chairman Galassie?
12 CHAIRMAN GALASSIE: Yes.
13 MR. ROATE: That's seven votes in the
14 positive, one in the negative.
15 CHAIRMAN GALASSIE: Motion passes,
16 congratulations. And I'm assuming you folks are
17 going to stay here for the next Item H02, Project
18 11-106, St. Joe Medical Center office building of
19 Highland.
20 You've really discussed this issue and
21 respect to you, I'm going to open it up to the board
22 for questions if there are any regarding the motion
23 to approve a three-story medical office building in
24 Highland.

1 Questions -- I'm sorry, Mike, your staff
2 report on this.

3 MR. CONSTANTINO: Thank you, Mr. Chairman.
4 The applicants are proposing to lease space in a new
5 three-story medical office building on the campus of
6 the new hospital. This medical office building will
7 contain approximately 58,000 gross square feet and
8 will cost approximately \$14.8 million.

9 There was no public hearing and no letters
10 of opposition received by the state board staff.
11 Thank you, Mr. Chairman.

12 CHAIRMAN GALASSIE: Thank you.

13 Any questions on the part of board
14 members?

15 MS. OLSON: I just need some clarification
16 here. This is confusing me. So St. Joseph's is not
17 building this building?

18 MS. SEBASTIAN: We are not.

19 MS. OLSON: Who is building the building?

20 MS. SEBASTIAN: It's an unrelated third
21 party.

22 MS. OLSON: So why do they have to get our
23 approval if they're not the ones not building the
24 building? That's what's confusing to me.

1 MR. CONSTANTINO: It doesn't meet the
2 requirements of necessary parties to a transaction.
3 That's in our rules.

4 MS. OLSON: Explain that.

5 MR. CONSTANTINO: We define necessary
6 parties as a person who hold or currently hold the
7 license, which the hospital does. The person who
8 has final control of the person who will hold the
9 license, which is the Hospital Sisters, Inc. and
10 Hospital Sisters Health System, any related person
11 who is or who will be financially responsible for
12 guarantee or making payments on any debt related to
13 the project. We do not consider this person to be a
14 related party, the developer. Related party defined
15 in our rules is generally someone that the parent
16 has a 50 percent control of.

17 And finally, any person who actively is
18 involved in the operation or provision of care and
19 who controls the equipment or capital access, and
20 they didn't meet that requirement either, so that is
21 why that developer is not a co-applicant on this
22 application.

23 CHAIRMAN GALASSIE: Clear as mud?

24 MS. OLSON: Yeah. I don't even understand

1 what we're voting on.

2 MR. URSO: Maybe I can say something. The
3 reason this is coming before the board and the board
4 has jurisdiction over it is because, number one,
5 it's above the capital expenditure minimums. This
6 is, as I see it, a \$14.8 million project.

7 MR. CONSTANTINO: It's by and on behalf of a
8 health care facility.

9 MR. URSO: That was going to be my next
10 point. And so it's above the capital expenditure
11 minimums and because it's being built by or on
12 behalf of a hospital, which they are, those are the
13 two triggers that then allow it to fall under the
14 board's jurisdiction. So because I or on behalf of
15 the hospital, the capital expenditure minimum for
16 hospital is 11.8 million, so we are at 14.8 million,
17 plus it's also being built on behalf of the
18 hospital. Because of those two triggers, that's why
19 this has come before the board.

20 MS. OLSON: Thank you, that helps.

21 MR. GREIMAN: Let me understand this. Who
22 is paying the 14 million 8 is to build this
23 building?

24 MS. SEBASTIAN: The 14 million is to build

1 the building and then it includes some of the build
2 out then for the occupation of the hospital site of
3 the facility.

4 MR. GREIMAN: And the hospital is paying the
5 \$14 million?

6 MS. SEBASTIAN: No, sir, we're spending
7 about \$4 million to build out the space that would
8 be hospital space so there will actually be
9 components or departments and services that are
10 normally a part of the hospital. They will reside
11 in this adjacent medical office building.

12 MR. GREIMAN: So the building itself is
13 being built by whoever the person who owns it is.
14 And substantially the cost of the building is
15 14 million and you're bringing \$4 million to
16 establish your area?

17 MS. SEBASTIAN: Yes, sir.

18 CHAIRMAN GALASSIE: Hearing no other
19 questions, may I have a motion to approve Project
20 11-106 for leasing an office space and a three-story
21 medical office building in Highland, Illinois.

22 MR. HILGENBRINK: So moved.

23 MR. EAKER: Second.

24 CHAIRMAN GALASSIE: Moved and seconded.

1 Roll, please.

2 MR. ROATE: Motion made by Mr. Hilgenbrink,
3 seconded my Mr. Eaker.

4 Dr. Burden?

5 DR. BURDEN: Yes.

6 MR. ROATE: Mr. Eaker?

7 MR. EAKER: Yes.

8 MR. ROATE: Judge Greiman?

9 MR. GREIMAN: Yes.

10 MR. ROATE: Mr. Hayes?

11 MR. HAYES: Yes.

12 MR. ROATE: Mr. Hilgenbrink?

13 MR. HILGENBRINK: Yes.

14 MR. ROATE: Ms. Olson?

15 MS. OLSON: No.

16 MR. ROATE: Mr. Sewell?

17 MR. SEWELL: No.

18 MR. ROATE: Chairman Galassie?

19 CHAIRMAN GALASSIE: Yes.

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

22 CHAIRMAN GALASSIE: Motion passes.

23 Congratulations and your presentation and

24 application rivals our largest systems, so very well

1 done.

2 MS. SEBASTIAN: Thank you very much.

3 CHAIRMAN GALASSIE: You're welcome.

4 I suggest we -- it's 11:30 by my watch --
5 that we take a ten-minute break and resume back
6 here, approximately, 11:40. Thank you.

7 (A BRIEF RECESS WAS TAKEN.)

8 CHAIRMAN GALASSIE: We will go back on the
9 record, please. We are moving on to Project Number
10 11-107, Northwest Memorial Hospital Outpatient Care
11 Pavilion. We have eight public comments under
12 request. We will have the two in opposition first
13 and, Juan, will read your names off. If you'll
14 please come up and just introduce yourselves, and
15 spell your name to our reporter. Swearing in is not
16 necessary.

17 MR. MORADO: We have Mr. John Reinholtz and
18 the other gentleman, George Georigiou,
19 G-E-O-R-G-I-O-U-S.

20 CHAIRMAN GALASSIE: Good morning. We've
21 read the rules and we appreciate your adherence to
22 our guidelines and you have the microphone in front
23 of you.

24 MR. GEORGIOUS: Thank you. I'm George

1 Georgious, I'm the president of 230 East Ontario
2 Condominium Association and I appreciate --

3 CHAIRMAN GALASSIE: You need to slow down a
4 little bit too, sir.

5 MR. GEORGIOUS: All right. I will do that.
6 I'm George Georgious. I'm the president of 230 East
7 Ontario Condominium Association and appreciate the
8 opportunity to make a brief presentation here today.

9 Our association represents the residents
10 who live at 230 East Ontario, which is the building
11 closest in proximity to the site of the proposed
12 outpatient pavilion. In fact, if construction
13 proceeds, our building and the medical office
14 building will be approximately 3 feet apart. Our
15 residents will be impacted most by this project.
16 Please note out of respect to the board's desire to
17 have comments made to the public hearing process,
18 once we learned about the ability to call a public
19 hearing it was too late.

20 Second, we acknowledge that our
21 association did not raise CON specific issues during
22 the zoning process. We respect the zoning process
23 and only offer comments appropriate to zoning in the
24 forum. Similarly, we will focus only on CON related

1 manners in this forum today.

2 We want to draw the state board's
3 attention to the Chicago Tribune article from
4 February 19. We firmly believe the state board
5 should not act on Northwest's proposal until it
6 considers the points raised in this article. The
7 article focuses on how a recent spending spree by
8 Chicago area hospitals underscores a raise to gain
9 and hold to market share. The article asks that
10 nearly every major hospital system in the region is
11 investing hundreds of millions into upgrades, adding
12 that it is doubtful that there is room for all of
13 them to survive.

14 According to one industry observer,
15 Chicago area hospitals are taking on record amounts
16 of debts. This observer believes that the billions
17 of the dollars hospitals spent collectively on
18 modernization could push some lesser stabilized
19 hospitals out of business unable to compete.

20 Accordingly, we believe the state board
21 should determine what Chicago hospitals are at risk
22 before approving this proposal. Another expert
23 contends that in the end some portion of this cost
24 has to be built into the rates hospitals are

1 charging. That translates into higher monthly
2 premiums or higher deductibles for consumers.

3 Finally, I want to let the board know that
4 Northwestern has already started sending out letters
5 to neighborhood organizations to notify us of the
6 construction on the property adjacent to ours will
7 begin in the next few months. We were surprised to
8 receive this letter because this board has yet to
9 vote on this matter. Unfortunately, Northwestern
10 appears to have already assumed your approval.

11 When we approached Northwestern during the
12 zoning process it we David versus Goliath. Goliath
13 won in that forum. Today we are once again David
14 facing Goliath. Please reject this application and
15 direct Northwestern to focus more on our concerns
16 and today we ask that you let David win. Thanks for
17 your consideration.

18 CHAIRMAN GALASSIE: Thank you. Can you tell
19 me again who your organization is?

20 THE WITNESS: 230 East Ontario Condo
21 Association.

22 CHAIRMAN GALASSIE: Condo association?

23 MR. GEORGIOUS: Correct.

24 CHAIRMAN GALASSIE: Thank you very much.

1 MR. HILGENBRINK: What's your relationship
2 with the condominium building, owner?

3 MR. GEORGIOUS: I'm the president and also
4 an owner, yes.

5 MR. HILGENBRINK: You're an owner. You have
6 a management ability?

7 MR. GEORGIOUS: No.

8 CHAIRMAN GALASSIE: Thank you.

9 MR. REINHOLTZ: Good morning, I'm Joel
10 Reinholtz. I am legal counsel to 230 Ontario Condo
11 Association and I too am here to ask this board to
12 deny the application by Northwest Memorial Hospital
13 until further explanation and evidence is presented
14 for need of this project and the burden on the
15 residents of 230 East Ontario is addressed better
16 and more specifically to their concerns.

17 One point I would like to really raise
18 briefly is in our letter, we -- or Northwestern
19 claims we made an inaccurate statement about charity
20 care. We are not here to argue semantics, however,
21 we did provide an article from the Chicago Tribune
22 from August 2011 that does assert the points raised
23 in our letter about Northwestern being denied a tax
24 exemption for not having sufficient charity care.

1 That was the letter, I won't belabor that point. We
2 believe it continues to be a fair point to raise.

3 In regards to certificate of need
4 application for this project, the cost is
5 \$322 million. That is 33 times higher than the
6 capital expenditure minimum. So we believe this is
7 clearly within the purview, even though it is a
8 medical office building, of this board.

9 The primary purpose of CON is to assess
10 the financial burden on patients that may result in
11 unnecessary health care construction. As Georgio
12 pointed out in his article, costs are often passed
13 on to patients through premiums and higher co-pays.
14 So if a project is not necessary, this board should
15 be looking at that. For example, the John Buck
16 study that they quote did not actually assess the
17 kind of hospital which has over 300,000 available
18 square feet. That building right now is vacant and
19 not being used.

20 Landmark Illinois who joined us in our
21 opposition is not able to be here today. They are
22 also actually addressing that particular building
23 today.

24 The John Buck study, the John Buck company

1 also created an independent study apart from the
2 Northwestern one which calls the Chicago office
3 market unstable and may require years to return the
4 stability. So we are not convinced that
5 Northwestern has shown an adequate proof that this
6 building will actually be filled.

7 We appreciate your consideration. We did
8 lay out our points in the letter and thank you for
9 your time.

10 CHAIRMAN GALASSIE: Thank you. Appreciate
11 your comments. We will now call to the table the
12 individuals that have requested public comment in
13 support of this project.

14 MR. MORADO: Philip Levin, Brian Hopkins,
15 Brian Kiddle, Sarah Burcke.

16 CHAIRMAN GALASSIE: Thank you.

17 We will start closest to our recorder,
18 just introduce yourself and spell your name for her
19 please.

20 MR. LEVIN: Sure. Good morning. I am
21 Philip Levin, that's L-E-V-I-N. I am the Planning
22 Director of the Greater North Michigan Avenue
23 Association which is an organization of over 700
24 businesses and institutions in North Michigan Avenue

1 area in Chicago. The association was formed exactly
2 100 years ago this year in 1912 to carry out the
3 vision of the burden plan of Chicago.

4 I've been the planning director at the
5 association for the past six years. And prior to
6 this I was with the City of Chicago for 27 years,
7 but the last ten years as Assistant Commissioner in
8 the Zoning Division of the Department of Planning
9 and Development. In this position, I negotiated
10 zoning and land use issues in hundreds of city
11 projects and planned developments which were
12 presented to the Chicago Plan Commission.

13 The Greater North Michigan Avenue
14 Association has a very active planning and advocacy
15 division, which primary mission is to maintain and
16 enhance the building environment.

17 One of the key committees in our division
18 is our project review committee. Members on the
19 project review committee are architects, planners,
20 traffic and parking experts and real estate
21 specialists who work in downtown Chicago and
22 throughout the Chicago area. This committee reviews
23 all significant projects proposed in the area and we
24 forward our recommendations to the local alderman's

1 office, to the city zoning administrator and to the
2 Chicago Planning Commission.

3 In 2012, Northwestern Memorial Hospital
4 representatives met several times with our project
5 review committee presenting plans for the new
6 outpatient care pavilion to be located at Erie and
7 Burbanks in the South Streeterville neighborhood.

8 After extensive review by the committee,
9 the committee complemented the development team on
10 several features of the project, especially the
11 overall design of the project, a provision on east
12 site for the necessary widening of Fairbanks Court,
13 and for the provision of drop off for patient within
14 the site rather than on the busy adjacent streets.

15 The committee also requested that the
16 hospital incorporate its loading dock below grade
17 and to reduce the number of curb cuts on the
18 sidewalks, and these changes were made and have been
19 incorporated into the final plans.

20 Since the review of this project by our
21 project review committee, the association has heard
22 that there are several parties that would like the
23 hospital to build a smaller building on the site and
24 to lease space in existing commercial buildings for

1 physician offices. Working with the developers and
2 medical office space for several years, I am well
3 aware of the advantages of having medical offices in
4 a unified facility. The utility needs for medical
5 offices are totally different than for general
6 office users.

7 Also having off street dropoff and pickup
8 accommodation is a crucial element. Disbursing
9 medical office space throughout the neighborhood
10 would mean a dropoff and pickup at those buildings
11 would impede traffic flow in the area's busy
12 streets.

13 Our committee strongly supported the plan
14 for one integrated office building that incorporates
15 dropoff within the site and is connected to other
16 campus buildings including the parking garage to the
17 east. A letter of support was presented from our
18 project review committee and sent to the Chicago
19 Planning Commission in November of 2012.

20 Thank you this morning for the opportunity
21 to comment and I encourage all of you to endorse
22 this project which would be a wonderful addition to
23 the medical campus, to the neighborhood and to the
24 city of Chicago. Thank you.

1 CHAIRMAN GALASSIE: Thank you Mr. Levin.

2 MR. HOPKINS: My name is Brian Hopkins.

3 H-O-P-K-I-N-S. I'm a member of the Board of
4 Directors of SOAR, the Streeterville Organization of
5 Active Residents, which is a community organization
6 encompassing the neighborhood of Streeterville where
7 Northwestern's campus is located. Up until a few
8 months I was president of the organization.

9 I was president during the time when
10 Northwestern first approached us with plans for this
11 development, and I also testified in support of this
12 development at the Chicago Planning Commission
13 hearing, which was at the conclusion of a rather
14 remarkable and lengthy process of public review.

15 Just to give you some perspective. We had
16 more community meetings on this project proposal
17 than we did for the now defunct Chicago Spider,
18 which at the time was proposed to be the world's
19 tallest building in the Streeterville community.
20 The opportunity for public input on this project was
21 extensive and unprecedented. We sponsored two very
22 well attended community hearings in conjunction with
23 the alderman's office. We had over a dozen smaller
24 meetings with the various condo associations,

1 including the folks who were here earlier from 230
2 Ontario. There were numerous meetings with other
3 organizations and stakeholders in the area. It went
4 on for quite some time and there was ample
5 opportunity for public input and participation
6 during this process.

7 As a result of all of that input, I would
8 like to commend Northwestern once again for the
9 major design modifications that they made for this
10 proposal as a result of the extensive commentary
11 from the public. Mr. Levin mentioned just a couple.
12 One we felt was most substantial was relocating the
13 loading docks to below grade, at great expense I
14 would add, to the construction budget.

15 Also completely redesigning the pedestrian
16 experience in the surrounding area. Reducing the
17 number of curb cuts and showing great sensitivity to
18 the additional traffic that the Outpatient Care
19 Pavilion would likely result in.

20 As a result of all of this, SOAR's board
21 of directors voted to support this project. We
22 publicized that and, as I mentioned previously,
23 submitted favorable testimony to the Chicago
24 Planning Commission.

1 For that reason I am here today, we felt
2 that, as a result of the extensive give and take
3 during the lengthy public review process and the
4 good faith compromise that was demonstrated by
5 Northwestern, we want to stand by our support for
6 this and we would urge you to approve the
7 certificate of need application. Thank you.

8 CHAIRMAN GALASSIE: Thank you very much.

9 MS. BURCKE: Good morning, members of the
10 board. My name is Sara Burcke, I'm Director of
11 External Affairs for the hospital. I'm here to read
12 a letter on behalf of one of our hundreds of
13 patients who received charity care from Northwestern
14 Memorial Hospital. This letter is submitted by
15 Annette Jo Giarrante.

16 "In March of 2007 I received a heart
17 transplant at Northwestern. I am grateful for this
18 new chance for life. In order to maintain my
19 overall health, and especially the health of my new
20 heart, I need to follow certain regimen and
21 follow-up care. This requires many trips to the
22 hospital to see numerous doctors and health care
23 staff, all kinds of lab and blood tests and routine
24 surgical outpatient care, and occasional overnight

1 stays in the hospital. When a specific issue or
2 problem comes up, so does the frequency of health
3 care visits.

4 "This also means that there is a steady
5 flow of bills. The expenses of the heart transplant
6 and follow-up care is far beyond my means. Even
7 with health insurance I cannot take care of all the
8 bills myself. From the very beginning Northwestern
9 offered me financial aid. This has helped to
10 relieve the burden of my health care costs. In
11 turn, this relieves my stress and contributes to my
12 overall good health and quality of life.

13 "In the five years since the transplant
14 the hospital has never withdrawn their financial
15 support. Their support has included discounts on my
16 balances and payment plans. Whenever I have
17 contacted them they are always responsive, concerned
18 and dedicated to help in whatever way possible.

19 "Previous to my transplant I received care
20 from many other Chicago land medical centers and
21 never once felt the concern and commitment about my
22 medical bills that I have from Northwestern.

23 "I will forever be grateful to
24 Northwestern for their exceptional medical,

1 financial and emotional support. Thank you for
2 giving me this chance to voice my sincere gratitude
3 for all that I received at Northwestern Memorial
4 Health Care."

5 Again, this patient is Annette,
6 A-N-N-E-T-T-E, Jo, J-O, Last name G-I-A-R-R-A-N-T-E.

7 CHAIRMAN GALASSIE: Thank you, Miss Burcke.

8 MR. KITTLE: I'm Brian Kittle, K-I-T-T-L-E.
9 I'm with Facilities Management for Northwestern
10 University and I want to clarify for the record that
11 Northwestern University and Northwestern Memorial
12 Hospital are two separate organizations, and that
13 the property at 333 East Superior and the building
14 referred to as the Old Prentice Building and also
15 the Stone Pavilion is owned by Northwestern
16 University and the university has no intention of
17 selling the property.

18 For 15 years the university has been
19 consistent and transparent that the 333 Superior
20 property will be used to build a state of the art
21 medical research building. This is in keeping with
22 the goals of the university and the mission of the
23 medical school to be within the top ten medical
24 centers nationwide.

1 We initiated and completed extensive
2 studies with nationally renown consultants to
3 evaluate the present structure at 333 Superior to
4 determine if the building could be re-purposed as a
5 medical research building. They determined that,
6 even with costly renovations, the building would not
7 be able to provide the space required to meet the
8 research needs of the university and could not be
9 renovated or retrofitted to meet the technical
10 standards that are required for a medical research
11 facility.

12 The demolition of the 333 Superior
13 structure and construction of a mounted research
14 building there would allow the university to rapidly
15 increase need for medical research on property
16 within its existing campus that will connect other
17 university medical research buildings. Our
18 ownership and development of the property at 333
19 Superior was critical to the future growth of
20 Northwestern and the growth of its medical school.

21 CHAIRMAN GALASSIE: Thank you, Mr. Kittle.

22 DR. FRANCIS: Go morning, my name is
23 Dr. Lee Francis, F-R-A-N-C-I-S, and I am president
24 and CEO of Erie, E-R-I-E, Family Health Center.

1 Erie Family Health Center is a non-profit community
2 agency that provides primary health care to over
3 37,000 low income patients at 11 service locations
4 on the west and northwest sides of Chicago,
5 regardless of their ability to pay. Over 98 percent
6 of our patients live below twice the federal poverty
7 level which is only \$44,000 for a family of four.
8 Over one-third of our patients have no health
9 insurance at all, and over two-thirds do not speak
10 English as their primary language.

11 Every year thousands of specialist
12 appointments, diagnostic tests, mammograms,
13 surgeries, ER visits and hospital stays are provided
14 by Northwestern at no cost to our low income
15 uninsured patients. The care is highly coordinated
16 with us and efficient.

17 Northwestern's collaboration with us
18 extends way beyond the traditional definitions of
19 charity care. With Northwestern's support, patients
20 receive needed services at our neighborhood
21 locations as well. A community based diabetes
22 control program addresses an epidemic of diabetes
23 with education and counseling. An eye care program
24 prevents blindness with patients -- for patients

1 with diabetes or HIV-AIDS. And a breast cancer
2 screening program identifies women in needs of
3 mammograms and links them to free tests.

4 We jointly established a community based
5 program to train the next generation of family
6 physicians to serve high need neighborhoods, one of
7 only 11 in the country and the only one in our
8 state.

9 Centralizing diagnostic and specialty
10 services on campus will help our patients get the
11 care that they need by coordinating it in one
12 location rather than fragmenting it in scattered
13 locations. Our patients have many extreme barriers
14 to accessing health care including transportation,
15 cultural challenges and literacy. Northwestern's
16 new outpatient care pavilion will help to mitigate
17 these important barriers. Thank you.

18 CHAIRMAN GALASSIE: Thank you, Dr. Francis.

19 MR. SULLIVAN: I am David Sullivan,
20 S-U-L-L-I-V-A-N, the same as Bill Sullivan in the
21 previous presentation.

22 I'm formerly director of planning for the
23 VA Chicago Health Care System. I'm here to urge you
24 to approve Northwestern Memorial's proposal to

1 construct a new outpatient facility and to reject
2 the proposal of some to lease space in existing
3 commercial office buildings, and I'm going to
4 explain why.

5 In 2008, the VA closed Lakeside Hospital,
6 which was located just east of the Northwestern
7 Memorial Hospital. Simultaneously the VA opened a
8 small 10,000 square foot clinic in the immediate
9 area. I was involved in that process. After
10 extensive and lengthy search we finally did find
11 space, but the challenges were significant and the
12 compromises we had to make were many. This would be
13 magnified many fold for Northwestern having a much
14 larger multi-specialty clinic and might even require
15 scattered site rather than a single location which
16 is not a desirable outcome.

17 Not all commercial buildings are
18 interested in having medical clinics, first of all.
19 Some are interested perhaps, but even then they have
20 limits on the number of clinics that they will
21 accept. Considering all available space in the area
22 as potential for leasing a clinic is an illusion in
23 my opinion and based on my experience, and even
24 should Northwestern find a willing partner in

1 promising spaces, not all may ultimately and
2 entirely satisfy Northwestern's requirements.

3 Design and build is a much preferable
4 over leasing existing commercial space. Commercial
5 office buildings have different purposes and
6 internal and external architectural and design
7 features than those required for a medical clinic.
8 Consequently, renovation is always necessary and
9 always costly. And it's often difficult or even
10 impossible to satisfy medical and engineering staff
11 exacting standards by life safety codes, room size
12 and space configuration.

13 Other problems have been mentioned before,
14 the dropoff and pickup, the parking, the wheelchair,
15 and gurney accessibility, security and medical
16 emergencies. These and other issues must be
17 considered and resolved. Not all are easy or
18 necessarily even possible to resolve efficiently in
19 existing commercial space. On the other hand,
20 design and build specifically for a medical clinic
21 resolves these issues up front.

22 I urge you again to approve the
23 Northwestern Memorial Hospital proposal.

24 CHAIRMAN GALASSIE: Thank you, Mr. Sullivan.

1 No other public comment. Thank you very much,
2 ladies and gentlemen.

3 I will now invite representatives of
4 Northwestern Memorial Hospital to the table to
5 discuss item 11-107 regarding the outpatient care
6 Pavilion.

7 Good morning, folks. If one by one you
8 can introduce yourself and spell your name for our
9 recorder, please.

10 MR. MCANNA: Peter McCanna. M-C-C-A-N-N-A.

11 MS. ORTH: Bridget Orth.

12 MR. WEBER: Ralph Weber. W-E-B-E-R.

13 MR. MURPHY: Dennis Murphy, M-U-R-P-H-Y.

14 DR. PEABODY: Dr. Terry Peabody.

15 P-E-A-B-O-D-Y.

16 MR. CHRISTIE: Rob Christie.

17 C-H-R-I-S-T-I-E.

18 MR. MLADUCKY: Jim Mladucky,

19 M-L-A-D-U-C-K-Y.

20 CHAIRMAN GALASSIE: We will do a collective
21 swearing in, please.

22 (ALL WITNESSES SWORN)

23 CHAIRMAN GALASSIE: Thank you very much.

24 Mr. Constantino, a staff report.

1 MR. CONSTANTINO: Thank you, Mr. Chairman.
2 The applicants are proposing to construct a 25-story
3 medical office building at a cost of approximately
4 \$323 million in approximately 999,000 gross square
5 feet of space. The state board staff notes there
6 was no public hearing and letters of support in
7 opposition were received by the state board staff.
8 Finally, the applicants have met all the
9 requirements of the state board.

10 Thank you, Mr. Chairman.

11 CHAIRMAN GALASSIE: Thank you, sir.

12 Would someone like to address the board.

13 MR. WEBER: Yes. Thank you, Mr. Chairman,
14 and members of the board. We appreciate the
15 opportunity to present our Outpatient Care Pavilion
16 project. We are excited to bring this unique
17 project here today and are very pleased to receive
18 an all positive state agency report.

19 Part of the reason why we were so excited
20 about this project is that it helps us advance the
21 vision that we call Northwestern medicine.
22 Northwestern medicine is a shared vision that joins
23 the Northwestern University Feinberg School of
24 Medicine with the Northwestern Memorial Health Care

1 in an unprecedented planning process to become one
2 of the nation's top ten academic medical centers.

3 By aligning our talents and resources, we
4 are focused on how health care is provided,
5 accelerating breakthrough research and fostering an
6 environment of academic excellence that supports the
7 training of outstanding caregivers. Together we
8 strive to change medicine in a way that can make a
9 great impact on people's lives, not just for
10 Illinois but nationwide. Our shared commitment to
11 transform health care will be accomplished through
12 innovation and excellence. The outpatient care
13 pavilion project will help make these
14 transformations in health care delivery.

15 Dr. Terrence Peabody, Chairman of
16 Orthopedics and Dennis Murphy, Executive
17 Vice-president of Northwestern Memorial Health Care
18 Chief Operating Officer of Northwestern Memorial
19 Hospital and the executive responsible for the
20 project will describe how this building will enhance
21 clinical care delivery at the event of national
22 health care reform. I will then cover a few
23 additional topics.

24 CHAIRMAN GALASSIE: Thank you.

1 DR. PEABODY: Good afternoon, Mr. Chairman,
2 and members of the board. The outpatient care
3 pavilion at Northwestern Memorial Hospital will
4 provide a health care home for several centers of
5 excellence. It will improve the health and well
6 being of patients in Chicago land and beyond by
7 bringing together multi-disciplinary teams of
8 physicians, nurses, therapists and other providers.
9 Patients will get timely and appropriate care based
10 on the nature and intensity of their problems by
11 bringing care providers together and out of their
12 traditional offices, which are more like silos.
13 There will be enhanced communication, implementation
14 of consistent treatment protocols, an ongoing
15 assessment of outcomes consistent with our mission
16 of patient care, education and research.

17 Plans are in development to make the OCP
18 home to programs which include medicine, diabetes
19 and musculoskeletal care. It will be similar to
20 other successful interdisciplinary programs at
21 Northwestern Memorial Hospital, namely the Lurie
22 Cancer Center and Bluhm Cardiovascular Institute.

23 These programs have successfully brought
24 providers from different fields together to focus on

1 diseases rather than their specialties and improve
2 the care and well being of the patient.

3 As an orthopedic oncologist, I work in the
4 Lurie Cancer Center with other surgical oncologists,
5 medical oncologists, psychologists and pain
6 specialists and many others providing care to
7 patients with cancer in a convenient and very
8 effective way.

9 The Outpatient Care Pavilion will allow a
10 similar approach for patients with other health care
11 issues. For example, a center of excellence in
12 musculoskeletal care. It's designed for the large
13 number of patients with musculoskeletal problems.
14 These problems account for a large proportion of
15 physicians each year, for everything from back pain,
16 sprain, strains, trauma, sports injuries and
17 arthritis. Often these patients receive disparate
18 and ineffective care depending on the type of
19 provider to which they are referred.

20 The goal of this center will be to provide
21 non-operative and operative care for patients with
22 these problems in a cost effective and efficient way
23 by directing patients to the most appropriate
24 provider. The Outpatient Care Pavilion allows for

1 these providers to be in a single location
2 facilitating communication and enhancing patient
3 outcomes. The patient will get the right kind of
4 care in a convenient location.

5 Thank you for appreciating that this
6 building is more than just a collection of doctors
7 offices. I appreciate your time and consideration.

8 CHAIRMAN GALASSIE: Thank you.

9 MR. MURPHY: Dr. Peabody has captured the
10 spirit of what this building is intended to achieve.
11 When we determined the need for outpatient surgery
12 and diagnostic space that could only be met in new
13 space contiguous to our existing facilities along
14 with the need for medical office space in our
15 immediate campus area, we realized we had a unique
16 opportunity. We have spent over 18 months planning
17 how this building will be a model for outpatient
18 care delivery in the country.

19 Newly designed operating systems will
20 promote efficient, timely patient scheduling,
21 coordination of appointments between medical
22 disciplines, prioritize diagnostic testing for
23 patients, visiting physician offices, instantaneous
24 records transmission and other features of efficient

1 and effective outpatient care delivery.

2 In doing so, the building will meet the
3 expectations of the community for efficient care as
4 well as meet the promises and challenges of
5 tomorrow's challenging health care landscape.

6 Health care reform insists that care be coordinated
7 and cost effective. The shift from inpatient to
8 outpatient care is accelerating.

9 Additionally, more than 1.3 million
10 additional residents of Illinois will have access to
11 health care insurance starting in January 2014. We
12 have placed a premium on delivering outpatient care
13 that will enhance capacity within our system.

14 This building will provide the economies
15 of scale and the efficiencies to meet this challenge
16 which are not achievable by unconnected offices
17 scattered throughout the greater downtown location.

18 Some have suggested that Northwestern
19 Memorial should not build this building and direct
20 funds instead to charity care in the community.
21 Those who claim that may not understand that
22 Northwestern Memorial provided over \$38 million in
23 charity care in 2010. This was the single largest
24 amount of charity care by any nongovernmental entity

1 in the State of Illinois. Only Stroger Hospital
2 provided more.

3 In 2011 we provided even more charity
4 care, \$44.2 million. We are very proud of this
5 commitment, and charity care is only part of the
6 calculation of chartable services we provide.

7 Charity care figure does not include
8 direct financial support and other health services
9 we provide at Erie Family Health Center as covered
10 by Dr. Francis. Also with another significant
11 federally qualified health center, the Near North
12 Community Health Center. Additionally Northwestern
13 partners with Community Health to provide care for
14 the uninsured and we have had a 30 year relationship
15 with Lawson House on Chicago Avenue.

16 Lawson House is home to 580 formerly
17 homeless individuals. At Lawson House, Northwestern
18 Memorial has established a free primary care clinic
19 and operates emergency housing and satellite mental
20 health services.

21 Letters from State Senator Raul and State
22 Representative Ken Duncan reference these
23 contributions.

24 With any outpatient care pavilion we have

1 designed a building that is connected internally as
2 well as physically and technologically to the rest
3 of our campus in a way that enables achievement of
4 new levels of care coordination between our
5 inpatient, outpatient and physician office settings.
6 Over the 18 months of planning we have set guiding
7 principles for the building geared to advance our
8 patients first mission. We call these principles
9 the five ones. One schedule, one registration, one
10 set of paperwork, one consolidated bill, and one
11 overarching role of zero unnecessary process
12 redundancies within the building. The project will
13 use the latest technology to improve integrated care
14 delivery and maximize operational efficiencies to
15 drive out costs.

16 The alternative suggested by neighboring
17 condo building are costly, inefficient and
18 impractical at best at best. At worst they will
19 result in our inability to provide adequate access
20 for outpatient procedures and physician office
21 appointments. These alternatives would have an
22 impact, an adverse impact on our patients. They
23 will also add significant congestion in our
24 neighborhood if patients have to travel to and from

1 multiple locations to see physicians.

2 Finally, there is an additional driver for
3 the need for this building. There is a need to
4 address the deficit of physician office space on our
5 campus. Over the past decade NMH has added 200 new
6 acute care beds to respond to the growing needs in
7 our communities. You and prior CON boards have seen
8 these projects. Two of the bed expansion projects
9 have been accomplished in part at the expense of
10 physician office space. The 15th and 16th floor of
11 the Prentice Women's Hospital with 72 oncologic beds
12 replaced two floors of offices originally planned in
13 the building for 100 physicians.

14 And more recently we constructed 24
15 med-surge beds, 23 ICU beds, and 12 observation beds
16 on Galter Pavilion's ninth and tenth floors only
17 after we relocated approximately 100 physicians from
18 those floors as well.

19 While we were reducing physician office
20 space to accommodate the demand for inpatient
21 services, our medical staff grew by over 600
22 physicians in the past decade. In part, the project
23 before you today restores a necessary balance to our
24 campus to provide needed physician office space.

1 I thank you for your time.

2 CHAIRMAN GALASSIE: Thank you.

3 MR. WEBER: The community process for this
4 project, as was referenced earlier, was very
5 extensive. As you can imagine, nothing, nothing
6 gets built in our community without significant
7 planning, expensive community review and city
8 planning department and aldermanic involvement. The
9 process included over 20 meetings attended by over
10 500 local residents and business people. You have
11 strong letters of support from the representatives
12 of the community, from several of the significant
13 residential buildings proximate to our campus,
14 including one of the two immediately adjacent to the
15 site. And from the local alderman who has to make
16 sure that important issues raised by residents are
17 sufficiently addressed.

18 Because we were responsive to comments
19 received during this extensive and rigorous process,
20 this project received unanimous approvals last year
21 by the city planning commission, the committee on
22 zoning, landmarks and building standards, and the
23 Chicago city council.

24 The hospital met three times with

1 representatives of the lone residential building
2 that has opposed this project. At no time in these
3 meetings or in the public meetings that they also
4 attended did representatives of this condo, this one
5 condo building, or anyone else, raise the issues
6 enumerated in the condo's opposition letter, namely
7 our need for the project, the claim that it is an
8 unnecessary expenditure of health care dollars or
9 challenge our level of charity care. Rather, their
10 issues were focused on site, zoning, setbacks and
11 circulation.

12 In our additional materials submitted to
13 you on February 8, we included a photo showing the
14 solid brick east walls of two residential highrise
15 buildings adjacent to our site, which is clear
16 evidence that, when those buildings were built 40
17 years ago, a large development on our adjacent site
18 was anticipated. And again, issues of site, zoning
19 setbacks were addressed in the city's extensive
20 review and approval process.

21 As suggested in the letters submitted by a
22 few of the owners of the condominiums and the one
23 building, views, rather than in the interest of
24 health care, seem to be the real issue for those in

1 opposition to the project. This issue was
2 appropriately addressed in the city zoning process.

3 I also want to comment briefly on the
4 suggestion that we utilize vacant space in
5 commercial office buildings in downtown Chicago.
6 For all of the reasons we stated in our application
7 and the additional materials we submitted on
8 February 8, scattered disbursed decentralized space
9 does not work for the kind of project needed in this
10 changing health care environment. Just because
11 there is tabulated vacant space doesn't mean it is
12 available or appropriate for medical offices.

13 Some of the buildings in the North
14 Michigan Avenue River North area do not accept
15 medical offices. Other buildings with vacant space
16 in the area, such as 737 North Michigan Avenue have
17 limits on the amount of medical offices they will
18 accommodate. They have realized that physicians
19 offices generate more need for elevators and parking
20 than other commercial offices and may require
21 additional building infrastructure. The vacancy
22 rate in the North Michigan Avenue area for buildings
23 that accept medical offices is only 6.3 percent.

24 The cost of baseline technology

1 infrastructure to support connection to required
2 networks is 300,000 to \$400,000 per building. So
3 scattering physician offices across many buildings
4 is not a good use of health care dollars.

5 Mr. David Sullivan, the VA guy, his
6 efforts to find a space to establish a health clinic
7 for veterans is a good example of the difficulty of
8 finding appropriate medical office space in
9 commercial buildings with vacancies. Some
10 commercial buildings also turn down health care
11 uses because they find them not compatible with the
12 building's image.

13 NMH had encountered such reactions with
14 some of our efforts to place outpatient programs in
15 commercial buildings. A good example would be our
16 outpatient psychiatry programs.

17 Much of the vacant space in the downtown
18 areas is in increments less than 10,000 contiguous
19 square feet. Because of the trend of physician
20 office practice consolidations, these smaller spaces
21 just don't work. The vacancy rate for buildings
22 that accept medical offices and have 100,000 square
23 feet of continuous space is zero. The largest block
24 in a building that would work for medical offices is

1 62,000 square feet, 980 North Michigan Avenue, over
2 seven blocks away, which is seven-tenths of a mile.

3 Picture a patient with orthopedic or
4 neurological mobility issues such as ALS,
5 osteoarthritis, MS, Parkinsons, being dropped off at
6 Northwestern Memorial in the drive-through plaza for
7 patient convenience, for diagnostic tests, and then
8 having to get to his or her doctor's appointment in
9 this space seven blocks away. This is the distance
10 of three laps around a football field. It is not
11 the kind of experience a patient will or should
12 tolerate.

13 And there are other reasons that vacant
14 spaces are not solutions. Restrictive building
15 hours of operation, lack of patient dropoff and
16 pickup capacity, if there are street level
17 entrances, even some ADA access issues still remain,
18 believe it or not.

19 More importantly, scattered vacant sites
20 do not contribute to the planned, coordinated,
21 integrated model that has driven the planning of
22 this building for the future.

23 Northwestern Memorial has been on the
24 downtown campus for over 140 years. We are number

1 two, Sister Sheila is number one, but 20 years
2 before us. And we plan to be there for another 140
3 years. Hopefully more.

4 Constructing buildings for our services
5 and physicians is more cost effective than leasing
6 in other buildings.

7 One final point. The suggestion of the
8 landmark advocates to force conversion of the old
9 Stone Pavilion to serve outpatient care pavilion is
10 problematic. As Mr. Kittle has said, Northwestern
11 Memorial Hospital does not own the building. It
12 belongs to Northwestern University. Yes, we do work
13 together, but they have their plans.

14 Our program requires 434,000 building
15 gross square feet for physicians offices. Not to
16 mention the additional space needed for surgery,
17 imaging and support. The Stone Pavilion is less,
18 about 360,000 building gross square feet, so it
19 doesn't meet our program.

20 Third, IDPH ruled at the time of the
21 decision to build the new Prentice Women's Hospital
22 in 2003, that the old Prentice Stone Pavilion can no
23 longer support surgery of any type because the
24 current infrastructure does not meet contemporary

1 code requirements. That ruling has been reconfirmed
2 in recent discussions.

3 Fourth, the Stone Pavilion has no parking.
4 Parking on the campus that formerly served the Stone
5 Pavilion serves the functions of obstetrics and
6 inpatient psychiatry that relocated out of the
7 building into the new Prentice Women's Hospital and
8 the Galter Pavilion, so the parking that had been
9 there now serves them in their different locations.

10 In addition, future parking capacity on
11 campus will be needed for Children's Memorial when
12 it relocates to our campus June from Lincoln Park.
13 The 575 new parking spaces in the outpatient care
14 pavilion are needed for functions of the outpatient
15 care pavilion.

16 And fifth, we calculated the total project
17 cost to convert the Stone Pavilion of physicians
18 offices. It is estimated at \$195 million. But
19 please keep in mind, that amount does not include
20 the cost to build the surgery, to build the
21 diagnostic testing, to build the parking and to
22 build the other elements of the proposed project
23 that cannot be accommodated in the Old Stone
24 Pavilion.

1 So once again, we are pleased to have
2 received a positive state agency report and we thank
3 you for hearing our comments and we finally would be
4 pleased to answer your questions.

5 CHAIRMAN GALASSIE: Thank you. I will open
6 it up to board members for questions.

7 MR. GREIMAN: So at this point, you're
8 putting almost a million square feet where that's
9 east of the garage, is that where this building is
10 going to be?

11 MR. WEBER: It's west of one of the garages,
12 Justice Greiman. It's between Erie and Ontario
13 Street on the west side of Fairbanks Court.

14 MR. GREIMAN: On the west side. But it's
15 going to be linked with Galter?

16 MR. WEBER: Yes, it is immediately south
17 across Erie Street from the Feinberg Galter Pavilion
18 and will be connected --

19 MR. GREIMAN: So you have a 20-floor
20 building that has all kinds of medical stuff in it.
21 Feinberg Galter, is that going to be emptied out?
22 Are you incredibly oppressed at this point that
23 you're going to a million square feet and also you
24 said that you will have doctors offices, at least

1 400,000 square feet, what's going to happen to that?

2 MR. WEBER: The Feinberg Galter Building is
3 the main inpatient care pavilion of the hospital.
4 It's got all of the inpatient beds apart from the
5 women's program and the oncology, hematology beds at
6 Prentice. It's a 2 million square foot building, it
7 is 100 percent occupied and will continue to be.

8 This is a supplement. This is a new
9 building that in part, as Dennis said, we have been
10 moving physicians out of the Galter Pavilion and
11 also we redid the plan for the Prentice Women's
12 Hospital where there were going to be 100
13 physicians. We changed those plans to add more beds
14 as we were growing in the last decade.

15 MR. MCANNA: I would add that there are
16 seven floors of 326,000 square feet for parking just
17 to clarify in that total.

18 MS. OLSON: I guess I just have a concern
19 that I would like to raise. I do understand and I
20 appreciate your comments and this is really more
21 than a question that this is an ideal way to
22 practice medicine. What I'm having a hard time
23 getting passed is with this economy and certainly in
24 health care justifying spending \$323 million on an

1 office building because I don't know that I can be
2 convinced that that doesn't translate into higher
3 health care costs that are passed on to the
4 patients.

5 Additionally, I would say that it is
6 disturbing to me when the gentleman says the letters
7 have already gone out to the area saying that
8 they're going to break ground in a couple of months.
9 I think that kind of says that you are just sure
10 that this is a done deal and I don't like that.

11 MR. WEBER: May I answer the second
12 question, and then either Dennis or Pete the first
13 question.

14 MS. OLSON: Sure.

15 MR. WEBER: They're good questions and we've
16 thought a lot about the first one as well. The
17 letter, this one is to Mr. Cain at the 230 East
18 Ontario Condominium Association and all the letters
19 were the same.

20 "Pleased be advised that Northwestern
21 Memorial Hospital intends to begin excavation of
22 future site of our Outpatient Care Pavilion, OCP,
23 located at 259 East Erie, pending state regulatory
24 approval."

1 That's the letter dated February 23rd. So
2 we never, never prejudged the State's
3 decision-making at this board.

4 MS. OLSON: Thank you for that
5 clarification. I appreciate that.

6 CHAIRMAN GALASSIE: Other questions from
7 board members?

8 MR. WEBER: I would make one comment on the
9 cost. We believe we have the demand for the
10 physician office space so that we need to house
11 those physicians somewhere, and given the fact that
12 we are a longstanding institution that will be in
13 that neighborhood for a very long time, hopefully
14 another 100 to 200 years, the most efficient
15 approach for us is to build a building to do it. .

16 Its immediate costs are significant but
17 over the life cycle of that project it's actually
18 the most efficient way in our opinion to actually
19 house those physicians and deliver that care in the
20 way that we feel that that is the best way to do
21 that.

22 MR. HAYES: When you mentioned about the
23 Stone building, is that correct, and some people
24 expressed opposition, I believe, because the Stone

1 building might be declared a landmark; is that
2 correct?

3 MR. WEBER: There is interest because it was
4 designed by Bertram Goldberg, the architect of
5 Marina Towers.

6 MR. HAYES: Okay. Now, what would happen
7 if -- so basically that's owned by the university
8 and they would like to tear that down and to build a
9 research center there and you have -- so basically
10 this project has nothing to do with that part of it.

11 MR. WEBER: It doesn't. That's correct.

12 MR. HAYES: Another question is that, in
13 some of the safety net hospitals that we have that
14 are very important to this board, they have
15 discussed the possibility under national health care
16 of basically having a significant problem of
17 competing against hospitals like yourself,
18 Northwestern, and other hospitals. There are many
19 hospitals in the area because simply their patients
20 with health insurance will be coming to Northwestern
21 and getting their health care there. How do you
22 plan on handling that type of situation? Are you
23 open to all comers who would have a new national
24 health care insurance?

1 MR. WEBER: Let me ask Rob Christie to
2 comment on that. And the other thing is, I'd like
3 to mention that over the 30 years of our past
4 history and before this board with our projects,
5 while we have been growing and building the Feinberg
6 Galter Building and the new Prentice Women's
7 Hospital, we always inform the other hospitals and
8 never once was there an opposition at a public
9 hearing or anything to our growth. We are trying to
10 be very oriented toward the community of health care
11 and not just toward Northwestern. Our needs are
12 defined based on the community and the system how it
13 is evolving.

14 MR. CHRISTIE: Good afternoon. My name is
15 Rob Christie. I'm Vice-president of External
16 Affairs for the hospital. And the answer to your
17 question about regarding health care reform and how
18 that might impact or affect relationships with
19 safety net hospitals, in January of 2014,
20 approximately, 1.3 million additional Illinoisans
21 will have access to care that don't have access
22 today through insurance. And, approximately,
23 700,000 of those, between 500 to 700,000 of those
24 individuals will get access through Medicaid. Most

1 of those who will become newly eligible are going to
2 be in the northern part of Illinois in and around
3 the Chicago region.

4 There is going to be an influx of care for
5 all of the hospitals that are out there now
6 regarding these people that will have access, and
7 that's wonderful because they won't be utilizing the
8 emergency departments as they have in the past as
9 their primary form of care. They will have more
10 utilization through the FQHCs, which you've heard
11 Dr. Francis talk about out relationship there.

12 Let me also give some background to the
13 board about our Medicaid, how we provide Medicaid.
14 We are the fifth largest provider of Medicaid in the
15 State of Illinois when it comes to patient
16 admissions. We're the eighth largest provider as
17 far as patient days, and that's according to the
18 most recent data from the Illinois Department of
19 Health Care and Family Services, so we see ourselves
20 as a very high volume Medicaid hospital. We think a
21 lot of the Medicaid patients will find care in their
22 neighborhoods, and again out of the emergency
23 departments, so we think there is room for all to
24 share in the new patients that will be coming

1 forward and we don't see this as a competitive thing
2 at all.

3 MR. HAYES: But some of these safety net
4 hospitals have expressed concern that basically
5 you're a competitor and they're going to lose out
6 from their patients that come.

7 In other words, they'll be stuck with
8 people that can't receive national health care.

9 MR. CHRISTIE: Again, there's not going to
10 be enough doctors in place by January of 2014 to
11 handle that influx so there's going to be plenty of
12 room for patients to go to all of the health care
13 facilities that are available to them in their
14 areas.

15 MR. GREIMAN: I don't know if my math is
16 correct. It looks like you do a little less than
17 3 percent of your net revenue is charity, cost of
18 charity, \$38 million you say to come in. So with
19 that, are you being concerned or directed or not
20 that you will not be a charitable -- be able to --
21 not have to pay real estate taxes because of your
22 charitable position or are you paying real estate
23 taxes?

24 MR. CHRISTIE: On this particular building

1 which will be the leased spaces will pay property
2 taxes on as we do now for our doctors office
3 pavilion which is primarily leased space. We do pay
4 property taxes on that.

5 As you know, there is a debate in this
6 state as to whether or not hospitals should earn
7 their tax exemptions, and part of that debate is how
8 much charity care does a hospital do. That's a
9 debate that we hope to have very fully this year
10 with the legislature. We've been engaged with
11 discussions through the Illinois Hospital
12 Association with such parties as the Governor's
13 office, the Department of Revenue, the Attorney
14 General's office, outside groups and interested
15 parties in coming up with hopefully an agreed to
16 solution on this issue.

17 It's complicated. We're working on it.
18 We know charity care will be a component of whatever
19 final solution is held.

20 MR. GREIMAN: Do you feel comfortable in
21 your 3 percent charity?

22 MR. CHRISTIE: If you will, Justice Greiman,
23 I've prepared a chart that I think will spell out
24 what we do in charity care in terms of where we

1 compare to the rest of the state. So this chart, if
2 you will -- can everyone see that?

3 This first bar graph shows our charity
4 care, which is the blue number right here from 2007
5 until 2011. The red line or the pink line
6 represents the average charity care contribution
7 from all hospitals in Illinois, with the exception
8 of Cook County because Cook County is an outlier.
9 We are second to Cook County as far as dollars, but
10 it's a percent of net patient revenue. That comes
11 to this chart here. So again, in the blue from 2007
12 to 2011 it shows you where our percent of net
13 patient revenue is. We're at 1.9 in 2007, we're at
14 3.0 in 2011.

15 Now, we only have data through 2010 from
16 the Department of Public Health, but it shows you
17 that the average percent of net patient revenue for
18 the average hospital in Illinois in 2007 was 1.5.
19 In 2010 it was 2.0. So our 3.0 is a continuing
20 increase above the statewide average when you take
21 Cook County out of the mix. We're very proud of
22 that.

23 Our charity care policy exceeds the state
24 policy in many, many different ways and that's where

1 these charity care numbers come from, primarily
2 because of where we're located, because of our
3 relationship with the FQACs that Dr. Francis talked
4 about, and because of our generous policies that we
5 have.

6 MR. GREIMAN: I want you to know that I was
7 not paid for that. But what is the other report?

8 CHAIRMAN GALASSIE: We want you to get your
9 money's worth.

10 MR. CHRISTIE: The other report is the top
11 ten hospitals in the state as far as charity care.
12 This shows that Cook County was nearly 100 million,
13 we were second -- this is for 2010. I haven't done
14 the 2011 because we don't have the collected data
15 yet.

16 For 2010 we were at 38.2. We were even
17 above in 2010 Shriners, which is 100 percent free
18 care hospital. So we're very proud of our charity
19 care members. We work hard.

20 CHAIRMAN GALASSIE: Is anyone turned away
21 for inability to pay?

22 MR. CHRISTIE: Our policy with the premise
23 that we provide care to all of those regardless of
24 their ability to pay.

1 CHAIRMAN GALASSIE: Thank you.

2 Member Hilgenbrink.

3 MR. HILGENBRINK: I noticed in your
4 application that you have consulting cost for LEED
5 certification. Was that motivated by philosophy or
6 is there a requirement for the City of Chicago to be
7 LEEDs and what level LEEDs are you shooting for?

8 MR. MLADUCKY: Presently we are tracking in
9 LEEDs Silver, we are certified and registered at
10 USGBC. The City of Chicago does have a policy on
11 green and LEED desire. And we are also conforming
12 to that.

13 We do have a philosophy that all our new
14 buildings will achieve at least LEEDs Silver and
15 we're focusing on reducing our carbon footprint by
16 2023 hoping to get it to neutral.

17 MR. HILGENBRINK: You are to be commended.

18 CHAIRMAN GALASSIE: Any other questions?

19 DR. BURDEN: Just briefly, about Obama care,
20 as a retired physician, I certainly have my own
21 opinion. Dr. Peabody to replace the chairman and my
22 pal for years.

23 DR. PEABODY: I did, there is no replacing
24 him.

1 CHAIRMAN GALASSIE: I will entertain a
2 motion to approve Project 11-107 to construct a
3 25-story medical office building in Chicago,
4 Illinois.

5 MR. HAYES: So moved.

6 MR. SEWELL: Second.

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

9 MR. ROATE: Motion made by Mr. Hayes,
10 seconded by Mr. Sewell.

11 Dr. Burden?

12 DR. BURDEN: Yes.

13 MR. ROATE: Mr. Eaker?

14 MR. EAKER: Yes.

15 MR. ROATE: Justice Greiman?

16 MR. GREIMAN: Aye.

17 MR. ROATE: Mr. Hayes?

18 MR. HAYES: Yes.

19 MR. ROATE: Mr. Hilgenbrink?

20 MR. HILGENBRINK: Yes.

21 MR. ROATE: Ms. Olson?

22 MS. OLSON: Yes, with reservations.

23 MR. ROATE: Mr. Sewell?

24 MR. SEWELL: Yes.

1 MR. ROATE: Chairman Galassie?

2 CHAIRMAN GALASSIE: Yes.

3 MR. CONSTANTINO: That's eight votes.

4 CHAIRMAN GALASSIE: Motion passes
5 unanimously. Congratulations. Good luck.

6 We find ourselves at 12:45. I'm going to
7 recommend that we break at this point for lunch. We
8 will attempt to be back here at 12:30, it may be
9 between 12:30 and quarter to 1 -- 1:30, excuse me,
10 we'll attempt to be back here at 1:30, and if not,
11 at the latest quarter to two.

12 Thank you very much. We are now in
13 recess.

14 (Lunch recess.)

15 CHAIRMAN GALASSIE: We are moving on to item
16 H04, project 11-018, Delnor Comprehensive Cancer
17 Center. No public comment. Do we have
18 representatives from Delnor here?

19 Good afternoon, welcome. If you folks
20 would just give the the standard introductions of
21 yourselves and spell your names, please.

22 MS. SKINNER: Yes, I'm Honey Skinner.
23 S-K-I-N-N-E-R. Also at the table is Luke McGuinnis
24 who is the CEO of Cadence Health. Jack Axle and

1 also at the table next to him Dr. Bayer, B-A-Y-E-R
2 and Tom Wright, Who is the CEO of Delnor.

3 CHAIRMAN GALASSIE: Thank you, folks.

4 Can we do a collective swearing in?

5 (ALL WITNESSES SWORN)

6 MR. MCGUINNIS: Good afternoon. My name is
7 Luke McGuinnis and I'm president and CEO of Cadence
8 Health.

9 CHAIRMAN GALASSIE: I'm sorry to interrupt
10 you, I'm just going to ask Mike for a quick staff
11 report and then come right back to you.

12 MR. CONSTANTINO: Mr. Chairman, the
13 applicants are Community Hospital and CDH Delnor
14 Health System are modernizing approximately 9,000
15 gross square feet of space in an existing medical
16 office building and adding approximately 30,000
17 gross square feet of new space for the provision of
18 outpatient oncology services at a cost of
19 approximately \$20 million.

20 No public hearing was requested and no
21 responses in opposition were received. We did
22 receive letters of support.

23 I would like to point out the applicants
24 exceeded a state board standard for modernization

1 costs and A&E fees for new construction. The A&E
2 fees for new construction when combined with
3 modernization are less than the standard.

4 The applicants have indicated that, should
5 this project be approved, they will stipulate that
6 A&E fees will not exceed the state board standard
7 when the A&E contract is developed.

8 Thank you, Mr. Chairman.

9 CHAIRMAN GALASSIE: Thank you.

10 Back to you, sir.

11 MR. MCGUINNIS: My name is Luke McGuinnis.
12 I'm president and CEO of Cadence Health. As you
13 recall, last year Tom Wright and I came before you
14 in connection with merger of Central DuPage
15 Hospital's parent organization and Delnor's
16 Hospital's parent organization. Together these two
17 hospitals now form Cadence Health. The hospitals
18 are separately licensed and the project that is
19 before you today relates to Delnor and will be
20 located on their campus.

21 I want to spend a few minutes before Tom
22 Wright addresses the project before you. To give
23 you an update regarding the merger that you
24 unanimously approved. Cadence is proud to report

1 that the merger is meeting and exceeding all
2 expectations, and that the response from our
3 communities has been extraordinary.

4 Our merger, as we had discussed with you,
5 had ambitious goals to bring the best practices and
6 care and delivery and improved access, reduce costs,
7 and most importantly, to improve the service we
8 deliver. Well before our hospitals ever merged, CDH
9 and Delnor shared a commitment to their respective
10 communities. Prior to the merger, I served for
11 eight years as CEO of CDH and throughout that
12 tenure. The CDH board's senior management and
13 clinical teams prioritized our commitments to the
14 underserved and uninsured in DuPage County.

15 CDH was the founding sponsor of Access
16 DuPage, which is a collaborative effort of
17 individuals and organizations to provide access to
18 medical services to the county's low income,
19 medically uninsured residents. Our support for
20 Access DuPage is significant and we believe it is
21 evidenced by real commitment.

22 Last year we contributed about a million
23 dollars. But more importantly, CDH does over the
24 50 percent of the hospital charity for all of DuPage

1 County.

2 Ten years later Access DuPage is
3 recognized as a national model of how local
4 communities can effectively work together to provide
5 a health care delivery system that covers all
6 residents who lack financial resources. We were
7 privileged that Senator Dick Durbin reached out to
8 us as a financial and clinical partner of Access
9 DuPage to brainstorm about how this model can be
10 exported to other communities.

11 Like CDH they, Delnor has consistently
12 demonstrated its commitment. Tom Wright, CEO of
13 Delnor will speak to that important role and then
14 speak to the project. Thank you.

15 CHAIRMAN GALASSIE: Thank you.

16 MR. WRIGHT: Good afternoon members of the
17 board and staff. We are honored and privileged to
18 present our project to you today.

19 Delnor has had a mission to provide
20 excellence in health care to the communities we
21 serve. We are very fortunate that, with
22 efficiencies and sound business practices, we have
23 been able to support patients that do not have an
24 ability to pay. But even beyond that, we've been

1 able to reach out into the community in a strong
2 relationship. An example would be with the Kane
3 County Board of Health, and board chairman and Paul
4 Cunnert, the executive director.

5 We were able to pick up vaccination
6 programs so the county couldn't afford them any
7 longer. We've worked with the county in conducting
8 the community needs assessment for the county and we
9 have additional examples such as supporting staff
10 and volunteers to a free clinic in St. Charles to
11 support our community. We also provide through an
12 affiliate corporation, Living Well Cancer Resource
13 Center, over a million dollars of free care per year
14 to patients that need initial psychosocial services
15 in support of their cancer diagnosis.

16 So we extend out into the families and
17 community and other neighboring hospitals
18 participate in that program as well. So we really
19 are viewed as a trusted partner in the community and
20 want to reach out and serve those who don't have the
21 ability to pay.

22 Today we come before you with, compared to
23 the projects before you, the \$20 million project for
24 a comprehensive cancer center I think is a very

1 efficient use of funds to expand our current
2 radiation facility into a comprehensive care center
3 by adding in breaking therapy and fusion therapy,
4 genetic counseling, physicians office space,
5 clinical trial administration, and survivor care
6 planning and mandates from the expanded cancer
7 registry program as dictated by changes in the
8 American College of Surgeons New Cancer Care
9 Accreditation Standards. And that consolidation
10 will allow the patients in our community to receive
11 comprehensive oncology related at a single location
12 which facilitates both their care and efficiencies
13 that we can realize by having a program in one spot.

14 You're probably very well aware of other
15 projects where there has been a single cancer center
16 and that is really the best in practice today and we
17 wanted to put that on our campus in a state of the
18 art oncology program. The Illinois Department of
19 Public Health Cancer Registry shows that Kane County
20 will continue to grow in cancer diagnosis by at
21 least 3 percent a year. And our experience has been
22 something greater than that.

23 Our program will eliminate the need for
24 patients to go back and forth between existing

1 radiation and therapy centers and office buildings,
2 and an assortment of other oncology related
3 programs.

4 We believe the project prioritizes the
5 immediate care needs of our patients while
6 increasing our efficiencies as a provider.
7 Therefore, we think it's a win-win and we are
8 grateful for your assistance that your staff has
9 looked at for this project and stand ready to answer
10 any questions.

11 CHAIRMAN GALASSIE: Thank you. I will open
12 it up to the board for any questions that they may
13 have.

14 MR. CONSTANTINO: Mr. Chairman, Mr. Hayes,
15 had brought to my attention last week that CDH
16 Delnor Health System had been -- had a name change,
17 Cadence Health. I contacted the applicants and they
18 did provide us with all of the relevant
19 documentation and the name change was after the
20 application was submitted.

21 CHAIRMAN GALASSIE: Thank you very much.

22 Questions from board members? Mr. Hayes.

23 MR. HAYES: Now, basically, Cadence Health
24 is made up of which organizations?

1 MR. WRIGHT: The two parent organizations,
2 Central DuPage Hospital and Delnor Hospital, and
3 their subsidiaries.

4 MR. HAYES: And this merger came before the
5 board, how long ago was it exactly?

6 MR. WRIGHT: About a year ago.

7 MR. HAYES: How far away is the Delnor from
8 Central DuPage?

9 MR. WRIGHT: 11.1 miles, directly west of
10 us.

11 MR. HAYES: It's directly west about
12 11.1 miles. And you're farther to the west there,
13 and you're in kind of the Kane County area of this.
14 What is the -- you know, I got some information from
15 the board staff that basically Central DuPage over
16 the past five years has almost a half a billion
17 dollars, \$450 million in approved projects. And
18 some of these, I think, or even or most of them may
19 actually be completed now. As well as project
20 number 08059 which is described as the Central
21 DuPage Hospital Cancer Center in Warrenville, and
22 that's for \$35 million alone.

23 Basically, I'm wondering about the need
24 for this facility since you are now combined and

1 you're only 11.1-miles away and Central DuPage has a
2 new cancer center and also has almost a half a
3 billion dollars in projects over the last five
4 years.

5 MR. MCGUINNIS: When we came before the
6 board, we being at that time CDH, because of your
7 rules and regulations and our commitment to not
8 build something beyond the community we served at
9 that time, we built a cancer center that was really
10 addressing our primary service area and it did not
11 have the inherent capacity to handle more than is in
12 our community. There was two vaults, they're
13 running at almost 100 percent occupancy.

14 The issue out at Delnor is they had a
15 vault and that facility over time is obsolete and,
16 because of its age, we're taking this opportunity to
17 combine medical oncology, fusion and the other
18 support activities Tom talked about with the actual
19 high energy device in MEV6.

20 MR. HAYES: And this actual high energy
21 device is where?

22 MR. MCGUINNIS: This one is on the Geneva
23 Campus at Delnor Hospital.

24 MR. HAYES: Okay. So, essentially, the

1 cancer center at Central DuPage really is for their
2 market area in particular and it does not serve the
3 Delnor which is 11.1 miles away.

4 MR. MCGUINNIS: No. Our center is located
5 in Warrenville and it is adjacent to the Proton
6 Beam, which is another facility that you approved,
7 we are a co-applicant on that issue. That was the
8 ninth Proton Beam in America, the only one in
9 Illinois.

10 MR. HAYES: But Warrenville is very close
11 to --

12 MR. MCGUINNIS: The actual location of the
13 center is about, I think, 5.2 miles from the Central
14 DuPage campus.

15 MR. HAYES: So it would be about 15 or
16 16 miles from Delnor?

17 MR. MCGUINNIS: Probably as the road goes,
18 but not as the crow flies.

19 MR. HAYES: Thank you.

20 MS. OLSON: You're talking about putting
21 this on Geneva campus?

22 MR. WRIGHT: Correct. There is an existing
23 8,000-square-foot building that houses the radiation
24 therapy and houses the accelerator.

1 MS. OLSON: On the Geneva campus?

2 MR. WRIGHT: On the Geneva campus, and we
3 would add 20,000 square feet around that structure.
4 That is where we get the efficiency there, it
5 becomes a \$20 million project to serve the needs of
6 the Delnor campus. You have the luxury of having
7 the room.

8 CHAIRMAN GALASSIE: Member Sewell.

9 MR. SEWELL: Yes. I want to make sure I'm
10 interpreting and understanding this cost issue
11 correctly. It looks like in the state agency report
12 on the issue of modernization and proportionate
13 contingencies, you're high. Then on architectural
14 and engineering fees you're high. But I think I
15 heard Mike say that you have said that, when you
16 negotiate the contract for your architectural
17 engineering fees, you will negotiate them so that
18 they will be within the state requirements. Is that
19 correct so far?

20 MR. WRIGHT: Correct.

21 MR. SEWELL: Okay. And I think he said that
22 the total costs, would the total costs then be in
23 compliance with our criteria at that point should
24 you negotiate the architectural and engineering fees

1 within the standard?

2 MR. WRIGHT: Yes.

3 MR. SEWELL: But the modernization and
4 contingencies alone would be just high, just that
5 the other stuff would be lower so that the whole
6 thing would be -- am I understanding that correctly?

7 MR. WRIGHT: Mr. Sewell, there were two
8 calculations done. One is the architectural fee
9 associated with the renovation component of the
10 project. That was above your norm.

11 The other one is the architectural fee
12 associated with the new construction component.
13 That was significantly below your norm and, in fact,
14 when you put the two together, they're okay.

15 MR. CONSTANTINO: Mr. Sewell, we have two
16 standards, one for new construction and one for
17 modernization in our rules, so that's why that's
18 broken out like it is.

19 MR. WRIGHT: But we would stipulate to being
20 within your terms.

21 CHAIRMAN GALASSIE: Any other questions by
22 board members?

23 MR. MORADO: I have a question about your
24 linear accelerator. If I understand you correctly,

1 there currently is one in Geneva already; is that
2 right?

3 MR. WRIGHT: Correct.

4 MR. MORADO: And the space you are hoping to
5 build will utilize that existing accelerator?

6 MR. WRIGHT: Correct.

7 MR. HAYES: Then in Warrenville you have
8 another accelerator; is that correct?

9 MR. WRIGHT: Correct.

10 MR. HAYES: Okay. So are these the two, so
11 there are two in Illinois; is that correct?

12 MR. WRIGHT: Proton Center is the only one
13 in Illinois and that's in Warrenville. Along at
14 Warrenville is a comprehensive cancer center that
15 was originally approved by this board for Central
16 DuPage Hospital. That has two linear accelerators.
17 The Delnor Campus today has one linear accelerator
18 housed only in a building that provides the
19 radiation therapy. This project brings on to that
20 medical oncology, the infusion capabilities of
21 putting it all in one building.

22 MR. HAYES: Thank you.

23 CHAIRMAN GALASSIE: Any other questions?

24 Hearing a motion to approve Project 11-108 for the

1 establishment of a cancer center in Geneva,
2 Illinois?

3 MS. OLSON: So moved.

4 MR. SEWELL: Seconded.

5 CHAIRMAN GALASSIE: Moved and seconded.

6 MR. ROATE: Motion made by Ms. Olson and
7 seconded by Mr. Sewell.

8 Dr. Burden?

9 DR. BURDEN: Yes.

10 MR. ROATE: Mr. Eaker?

11 MR. EAKER: Yes.

12 MR. ROATE: Justice Greiman?

13 MR. GREIMAN: Yes.

14 MR. ROATE: Mr. Hayes?

15 MR. HAYES: No, because of the duplication
16 of costs.

17 MR. ROATE: Mr. Hilgenbrink?

18 MR. HILGENBRINK: Yes.

19 MR. ROATE: Ms. Olson?

20 MS. OLSON: Yes.

21 MR. ROATE: Mr. Sewell?

22 MR. SEWELL: Yes.

23 MR. ROATE: Chairman Galassie?

24 CHAIRMAN GALASSIE: Yes.

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

3 CHAIRMAN GALASSIE: Motion passes,
4 congratulations.

5 Moving on to Project Number 11-112, Edward
6 Hospital. Any public comment?

7 (No response)

8 CHAIRMAN GALASSIE: Hearing none,
9 representatives from Edward Hospital, if you will
10 come to the table, introduce yourselves and spell
11 your names for our reporter, please.

12 MS. KENNEY: Annette Kenney, A-N-N-E-T-T-E
13 K-E-N-N-E-Y.

14 MS. MASTRO: Marylou Mastro, M-A-S-T-R-O.

15 MR. PRYOR: Vince Pryor, P-R-Y-O-R.

16 MS. RUNGE: Carrie Runge, R-U-N-G-E.

17 MS. COCHRAN: Lynn Cochran, C-O-C-H-R-A-N.

18 CHAIRMAN GALASSIE: Thank you.

19 If we could have a collective swearing in.

20 (ALL WITNESSES SWORN)

21 CHAIRMAN GALASSIE: Thank you.

22 MS. KENNEY: My name is Annette Kenney. I'm
23 Vice-president -- I'm sorry.

24 CHAIRMAN GALASSIE: We'll have a staff

1 report and come right back to you.

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

3 The applicants are proposing modernizing
4 their existing hospital in Naperville, Illinois and
5 they have 12 ICU beds and 36 medical surgical beds
6 at a cost of approximately \$63.6 million. We note
7 the following. There was no public hearing and no
8 letters of support or opposition.

9 This project was originally submitted and
10 approved as Project 07138 in February of 2008. That
11 project was all within 2009 and the cost of that
12 project was reduced by, approximately, \$48 million.
13 Regarding this project the applicant exceeds the
14 size standard for ICU beds by 8 gross square feet
15 per bed. And finally, the applicant's historical
16 utilization is not just by the number of med-surge
17 and ICU beds being requested. Thank you.

18 CHAIRMAN GALASSIE: Thank you.

19 MS. KENNEY: Thank you for the opportunity
20 to discuss this project with you. My name is
21 Annette Kenney and I'm Vice-president for Corporate
22 Strategy and Business Development at Edward Health
23 Services Corporation.

24 This project is a direct response to

1 continued growth and utilization at Edward Hospital
2 and in our immediate service area and is intended to
3 address local area bed needs, potentially relieve
4 the capacity issues that we're already experiencing
5 on a day-to-day basis.

6 The state agency report for this project
7 was extremely positive. With only 2 out of 13
8 applicable standards not met. Out of respect for
9 your time, I will focus my remarks on these two
10 items.

11 The first is, as Mike indicated, relates
12 to the size of the project where we very modestly
13 exceeded the size standard for ICU beds, in fact, by
14 8 gross square feet per bed. This was necessary due
15 to the fact that we were building over an existing
16 footprint and the building's configuration requires
17 additional square footage to meet requirements for
18 patient visualization and exterior windows.

19 However, the proposed size is well within
20 the the range of other projects that you have
21 approved, including projects for our own hospital.

22 The second standard that was not met
23 relates to our occupancy rate which fell modestly
24 below the state standard in calendar year 2010 which

1 is the most recently available data on the IDPH
2 inventory and, in fact, is what is included in this
3 state agency report.

4 As indicated in our certificate of need
5 application, the IDPH inventory records midnight or
6 12:00 a.m. census, and this is the number, again,
7 that is used in the state agency report. However,
8 as any of the clinicians present here will
9 acknowledge, midnight census does not provide an
10 accurate reflection of true bed needs since it
11 typically is the quietest time of the day. The
12 10:00 a.m. census is what we generally use to look
13 at our bed needs because it gives us a much better
14 indication. It's when the hospital is busiest and
15 the greatest demand for beds are in place at that
16 time.

17 In fact, our 10:00 a.m. census for
18 medical-surgical beds is typically nearly 10 percent
19 higher than the midnight census. So, in other
20 words, that means at 10:00 a.m. there's 12 to 15
21 more patients utilizing beds than there are at
22 midnight.

23 So when you look at our 10:00 a.m. census,
24 we do exceed state occupancy standards both for

1 medical-surgical and ICU beds with approximately
2 90 percent occupancy for medical surgical and
3 60 percent for ICU, and this is acknowledged in the
4 state agency report as well.

5 One thing to note about Edward Hospital is
6 that, unlike many other hospitals in the state, we
7 have absolutely no reserve capacity or unstaffed
8 beds to accommodate peak demand. So, in other
9 words, we have no place to put patients when we are
10 at our daily peaks or seasonal peaks, which occurs
11 frequently during the course of the year. This
12 requires us to hold patients in emergency rooms and
13 in our emergency department as well as in post
14 surgical, post procedural recovery areas for
15 extended periods of time until we can facilitate
16 discharges and free up extra beds.

17 Obviously, that's sub optimal from a
18 patient care quality, patient satisfaction, nurse
19 staffing and efficiency standpoint.

20 So my final point is that inpatient
21 utilization at Edward Hospital continues to grow.
22 We experienced 4 percent growth in medical-surgical
23 admissions in fiscal year '11 and year to date in
24 2012 we are seeing similar rates of growth.

1 We are already feeling the pain of limited
2 capacity and this will intensify as our patient
3 population continues to grow and more importantly as
4 it continues to age. We will need more beds to
5 accommodate the needs of our patients and we hope
6 you agree that this is a responsible means of
7 meeting that objective.

8 At this point, we will thank you and ask
9 if you have any questions.

10 CHAIRMAN GALASSIE: Thank you very much. I
11 will open it up to the board for questions.

12 Member Sewell.

13 MR. SEWELL: It is really directed to staff.
14 This occupancy criteria, this is what we talked
15 about before where the application meets the bed
16 standard but fails on the occupancy standard. Is
17 this the one that is somehow imposed on this by the
18 general assembly as a criteria? Wasn't that on a
19 prior application?

20 MR. CONSTANTINO: I think that was regarding
21 the inventory. In this situation, we require for
22 modernization that they put on our target occupancy
23 at 85 percent for med-surge bed, at 60 percent for
24 ICU. We use the data that is reported to us on the

1 hospital profile. That data is taken at 12
2 midnight. Annette is suggesting that we should be
3 using the 10:00 a.m. information because that's more
4 relevant and, if you accept that, they would meet
5 our target occupancy of 85 and 60 percent.

6 MR. SEWELL: But there is no problem with
7 beds?

8 MR. CONSTANTINO: The bed need, they're
9 arguing that their service area is in two different
10 planning areas, however, we only look at the
11 planning area they are located in, but their service
12 area is two different planning areas. A5 and A13 I
13 believe is the other one.

14 MS. KENNEY: Yes.

15 MR. SEWELL: But even when you looked at the
16 one they are located in, it did meet the bed need.

17 MR. CONSTANTINO: Yes.

18 MS. KENNEY: There is a bed need for 40 ICU
19 in A5.

20 CHAIRMAN GALASSIE: Dr. Burden.

21 DR. BURDEN: I have another question. Under
22 purpose for the project, we just had and approved a
23 collaborative effort between Central DuPage and
24 Delnor. I wasn't totally aware about their

1 collaboration and their union that occurred in both
2 institutions. I have been on the board now for
3 about six years. To accommodate new hospital
4 initiatives with Northwestern Medical Foundation and
5 DuPage Medical Center and the transcatheter
6 placement. I assume that is the same?

7 MS. KENNEY: No, actually that is separate
8 from that. We are affiliated with the Northwestern
9 Medical Foundation only for neurosciences.

10 DR. BURDEN: What's the transcatheter --

11 MS. KENNEY: That is our own program that we
12 are affiliated with, with Midwest Heart which is a
13 physician group.

14 DR. BURDEN: You're affiliated with
15 Northwestern Medical -- McCarthy is the world's
16 authority on this particular topic, at least among
17 the world's authority, he came from Cleveland Clinic
18 with that reputation and I don't think it's changed.
19 I don't understand some of what I read here. If you
20 are involved with the Foundation, you are not
21 involved with the major valve surgeon in our
22 community at least as a group. I don't quite get
23 what this is all about. Explain that for me.

24 MS. KENNEY: Our affiliation with

1 Northwestern is for neuro interventional services,
2 neurosurgery and neuro intervention.

3 DR. BURDEN: At DuPage Medical Center?

4 MS. KENNEY: DuPage Medical Group is another
5 affiliation we have with the --

6 DR. BURDEN: Not the hospital?

7 MS. KENNEY: No, not the hospital. They are
8 a completely different purpose. It's a 350
9 multi-specialty physician group who we partner with
10 in order to do managed care contracting. And to,
11 really our mission is to look at ways of improving
12 coordination across the ambulatory and inpatient
13 setting.

14 DR. BURDEN: And if that has something to do
15 with your application, I'm missing it.

16 MS. KENNEY: I think we are just trying to
17 explain some of the reasons why we see continued
18 growth at Edward Hospital and, again, because of our
19 commitment with DuPage Medical Group in this
20 partnership to achieve efficiencies having enough of
21 a capacity in order to manage patients appropriately
22 is very, very important. It is where health care is
23 going, where health care reform is going. This is
24 an answer to that.

1 DR. BURDEN: Health care reform is going
2 where?

3 MS. KENNEY: In a direction where we're
4 going to need to work more collaboratively with our
5 physicians to improve efficiency --

6 DR. BURDEN: Notice I refer to it as health
7 care reform. I'm being politically incorrect by
8 mentioning another name, to add to this health care
9 reform so-called, and it certainly isn't health
10 care, it's insurance reform. I'm a retired
11 physician, 45 years in practice. Those are all buzz
12 words, but I still don't see it, but that doesn't
13 distress me too much.

14 MS. KENNEY: I think the point of the
15 application is that the demand is growing.

16 DR. BURDEN: The demand is growing, yet
17 you're adding another group you have to service.
18 Somehow or other it's conflicting, but I'm listening
19 carefully to what you're saying and I think I can
20 appreciate it, although I find it a little obtuse.

21 CHAIRMAN GALASSIE: Other questions from
22 board members? Other title clarifications by
23 anyone?

24 (No response)

1 CHAIRMAN GALASSIE: Hearing none, may I have
2 a motion to approve project 11-108 for the
3 establishment of a cancer center in Geneva,
4 Illinois?

5 I'm sorry. Item 11-112. May we have a
6 motion to approve project 11-112 for the major
7 modernization of Edward Hospital in Naperville,
8 Illinois.

9 MS. OLSON: So moved.

10 MR. SEWELL: Second.

11 CHAIRMAN GALASSIE: Motion and second.

12 Roll call, please.

13 MR. ROATE: Moved and seconded, motion made
14 by Ms. Olson, seconded by Mr. Sewell.

15 Dr. Burden?

16 MR. BURDEN: Yes.

17 MR. ROATE: Mr. Eaker?

18 MR. EAKER: Yes.

19 MR. ROATE: Mr. Greiman?

20 MR. GREIMAN: Yes.

21 MR. ROATE: Mr. Hayes?

22 MR. HAYES: Yes.

23 MR. ROATE: Mr. Hilgenbrink?

24 MR. HILGENBRINK: Yes.

1 MR. ROATE: Ms. Olson?

2 MS. OLSON: Yes.

3 MR. ROATE: Mr. Sewell?

4 MR. SEWELL: Yes.

5 MR. ROATE: Chairman Galassie?

6 CHAIRMAN GALASSIE: Yes.

7 Motion passes unanimously.

8 Congratulations.

9 MS. KENNEY: Thank you very much.

10 CHAIRMAN GALASSIE: Item 11-06 Norwegian
11 American has been deferred so we will move on to
12 item H07 Regional Surgi Center. Any public comment?
13 No public comment. If representatives from Regional
14 would come to the table and introduce yourselves to
15 our reporter and give your spelling of your name.

16 MR. MOVVA: Arvind Movva. A-R-V-I-N-D, Movva
17 is M-O-V-V-A.

18 MS. FRIEDMAN: Kara Friedman, K-A-R-A. I'm
19 with the law firm of Polsinelli Shughart.

20 CHAIRMAN GALASSIE: Thank you.

21 Collective swearing in.

22 (ALL WITNESSES SWORN)

23 CHAIRMAN GALASSIE: Thank you.

24 Staff report, please.

1 MR. CONSTANTINO: Thank you, Mr. Chairman.
2 The applicants are proposing to add the surgical
3 specialty to a multi-specialty ASTC in Moline,
4 Illinois at a cost of approximately \$50,000. We
5 note the following. No public hearing was requested
6 and no letters of opposition were received by the
7 state board staff. Letters of support were
8 received. We do note three of the six facilities
9 within 30 minutes are not operating yet or target
10 occupancy of 80 percent.

11 Thank you, Mr. Chairman.

12 CHAIRMAN GALASSIE: Thank you. Comments
13 from the board?

14 MR. MOVVA: Good afternoon, Chairman, and
15 members of the board. My name is Arvind Movva. I'm
16 one of the physicians at Regional Surgi Center. I'm
17 also one of the medical directors there. With me
18 today is Kara Friedman who is our legal counsel who
19 assisted in the preparation of the CON application.

20 Regional Surgi Center is a multi-specialty
21 surgery center located in the Illinois quad City of
22 Moline. We are for the before the board today to
23 add a surgical speciality. We are seeking to add
24 ENT procedures to our existing surgical center and

1 requesting this board to remove the condition on our
2 permit requiring us to obtain a board approval prior
3 to adding surgical specialties to our surgery
4 center.

5 Importantly, no ambulatory surgical center
6 in at an Illinois quad city operates with a full
7 array of outpatient surgical services. With the
8 exception of a few limited specialities, patients
9 who want to have surgical procedures performed at a
10 low cost, high quality surgery care center must
11 leave the state and have these procedures performed
12 in Iowa.

13 Not only do the patients have to leave the
14 state, but their physicians must straddle the two
15 states as well, which requires a lot of extra
16 credentialing and licensing. This is not only
17 inconvenient on a day-to-day basis but puts an extra
18 burden on our physicians and our ability to retain
19 specialists in some of these areas.

20 Approving our application today will allow
21 the center to operate at an appropriate site and
22 care that the other residents of the state have
23 access to without having to travel out of the state
24 or a significant distance outside their immediate

1 community. There are 84 multi specialty surgery
2 centers in the State of Illinois. They are in towns
3 as small as a Centralia with a population of 13,000.
4 And Marion with a population of 17,000. There are
5 two multi-specialty ASEs as well as three in
6 Danville, which has a population of 33,000. Our
7 Illinois quad cities have a combined population of
8 82,000, yet the patients have to travel to Iowa to
9 undergo most surgical specialty procedures in an ASE
10 setting.

11 The hospital providers in our community
12 have either registered their support or neutrality
13 to this project.

14 Each of you as educated health care
15 consumers must appreciate that, if your son or
16 daughter or other family member needed an elective
17 procedure, you would rather see him or her receive
18 that care in an freestanding surgery center.

19 With respect to the addition of ENT, these
20 procedures are routinely performed in surgery
21 centers rather than hospitals. They are some of the
22 most common ASCT surgical procedures due to several
23 key factors. One, most ENT procedures are minimally
24 invasive. Two, surgery centers are efficient and

1 convenient for both physicians and patients. Three,
2 the environment is less intimidating than a hospital
3 setting for pediatric patients. Four, cost is lower
4 compared to hospitals.

5 For our pediatric patients,
6 Regional Surgi Center has pediatric advanced life
7 support and a certified anesthesiologist, and
8 therefor our pediatric patients will receive special
9 monitoring for accurate assessment of their status
10 while under anesthesia. Pediatric anesthesia care
11 requires a unique set of skills as well as strong
12 understanding of the physiological differences
13 between adults and children or infants.

14 Surgery centers provide high quality
15 surgical care, excellent outcomes and high level of
16 patient satisfaction at lower costs than hospital
17 outpatient departments. For example, median charge
18 for tonsillectomies at one of the local hospitals is
19 nearly \$5,000, whereas at Regional Surgi Center
20 charge for a tonsillectomy is roughly half that cost
21 at \$2,646.

22 Finally, I would like to discuss the two
23 negative findings in our state agency report. Both
24 findings impact our other facilities and change in

1 the scope of services pertaining to the capacity of
2 existing hospital performed ENT procedures.

3 As previously discussed, hospitals are not
4 the most appropriate setting for outpatient ENT
5 procedures. First, they are more costly and less
6 efficient. Also I do want to be clear that this
7 project will not have a negative impact on any
8 provider of the Illinois quad cities.

9 Dr. Cody, the referring physician, is
10 currently referring over 400 of his Illinois
11 patients to facilities in Iowa. Due to the reasons
12 discussed above, patients would prefer to travel to
13 Iowa to have these procedures performed in a surgery
14 center rather than at a local hospital. Therefore,
15 the addition of ENT will not negatively impact
16 existing hospitals. They will stem the
17 out-migration to Iowa and allow patients in the
18 Illinois quad cities to have these procedures
19 performed in a low cost, high quality surgery center
20 close to home.

21 We have had no objections from local
22 providers and, in fact, have had many letters of
23 support including from local Good Samaritan
24 Organization, a local pediatrician, a local family

1 physician who is employed by the local hospital, a
2 midwife and a local large employer.

3 We respectfully request the board to
4 approve our application at this time. We will be
5 happy to answer any questions from the board.

6 MS. FRIEDMAN: And if you don't mind, I have
7 a couple comments. I'll try to keep it short.

8 This is a little bit of a unique
9 situation. Just to reiterate, we are requesting the
10 board allow this facility which is designated as
11 multi-specialty to operate with an unrestricted
12 license and this would be consistent with how this
13 has been handled in nearly every other situation.

14 Unlike other multi-specialty providers,
15 this operator has an extensive history with this
16 board. It came before this board in 1992 when it
17 applied for a CON permit and at that time it
18 received an unrestricted permit to establish a
19 center.

20 At that time surgery centers were all
21 characterized the same and, therefore, it was
22 constructed in order to meet the needs of any
23 outpatient surgical patient which would include the
24 extended recovery areas in the larger operating

1 rooms. But because of some changes in the CON
2 policies around that time, this facility was
3 determined to operate as an admitted specialty
4 center and, at the time that it did open in 1995, it
5 was basically made in agreement with the board that
6 it would only do endoscopy procedures at this time.

7 In 1996 the CON board's rules changed so
8 that it now has two designations, you have the
9 limited speciality designation and you have the
10 multi-speciality designations.

11 So I think you're all familiar, limited
12 specialty, you either apply for one or two
13 specialties and, if you want to go beyond that, then
14 you need to apply for multi-specialty. Once you
15 have multi-specialty designation, which requires you
16 to demonstrate you'll have at least three types of
17 specialist surgeons providing services, then it
18 doesn't matter. You can allow your podiatrist to
19 come on or your OB-GYN or whoever it is that
20 typically does outpatient procedures.

21 So with the procedural history
22 specifically of this applicant because it was
23 determined to be limited specialty. In 2007 it came
24 before the board to request approval to add general

1 surgery and that was you unanimously approved.

2 Subsequently in 2010, it again requested
3 to add a specialty which was consistent with the
4 board's rules and they actually sought
5 multi-specialty designation two years ago. At that
6 time, however, a condition was placed on the permit
7 and we were required to come here again today. This
8 is the fourth specialty.

9 So we don't believe this condition is
10 consistent with the board's rules. I don't know if
11 you are contemplating a rule change, but we believe
12 that, as the rules are stated right now, we should
13 be able to proceed as a multi-specialty center.

14 This is the only multi-specialty center in
15 the quad cities and we really believe that the
16 community would benefit from having it. It's not
17 just the community, it's the government that pays
18 lower costs for Medicaid services and for Medicare
19 services at the federal level, it's employers and
20 patients.

21 So having to travel to Iowa for ASTC
22 services seems unnecessary given the capabilities
23 and, you know, there is really no building
24 expenditures required at this point in order to

1 proceed this way. So, you know, I think that states
2 the case generally as where we are.

3 CHAIRMAN GALASSIE: Thank you. I would like
4 to open it up to board members for questions.

5 Dr. Burden.

6 DR. BURDEN: Thank you, Doctor, for your
7 presentation. What is your medical specialty, may I
8 ask?

9 MR. MOVVA: I'm a gastroenterologist.

10 DR. BURDEN: You may have heard me on prior
11 issues, but if you haven't been around enough, but I
12 usually get difficult, even though I may not be
13 ordinant regarding surgery centers particularly, and
14 that accepting Medicare and Medicaid for which I
15 applaud. You add a little more than you have in
16 prior years. I'm not insisting you take it but I
17 insist that there be an application made for it so
18 that it may allow you to accept it. That's my
19 personal prejudice, period. I presume you do take
20 Medicare.

21 MR. MOVVA: We take Medicare, we take
22 Medicaid and we probably do approximately 7 to
23 8 percent Medicaid, which is, I believe, above
24 average. Really we take all payers. We don't turn

1 down anybody. We accept all insurances and all
2 people regardless of the ability to pay.

3 DR. BURDEN: I applaud you for that. I have
4 trouble accepting your comment. You may not know
5 this, I spent about 12 years of my professional life
6 in Children's Hospital where I was pretty impressed
7 that pediatric anesthesia was a unique entity and I
8 would not recommend my grandson to go to an
9 ambulatory surgical treatment center where I have a
10 pediatric institution in my community. You made a
11 comment how we would select this because we think
12 it's great. Well, you may think it's great, and I'm
13 not disputing it, but I'm not going to send my
14 grandkids to an ambulatory surgical treatment in
15 Chicago when you have Children's Hospital. I think
16 that comment, be careful with it.

17 MR. MOVVA: In this community I trained in
18 Chicago and there are great pediatric hospitals
19 here, but in our area, we just don't have that
20 option.

21 DR. BURDEN: I'm not saying that -- the fact
22 that you don't have it is one thing, but to make the
23 statement that you are deemed it at us, I'm one of
24 the nine or so sitting here that we would prefer to

1 have our kid or grandkid go to your service for our
2 care. No, that's our judgment, that's our call
3 where we send our grandkids or where we influence
4 their parents to send them.

5 MS. FRIEDMAN: Well, Dr. Burden, I don't
6 usually interrupt with a personal anecdote, but my
7 son had a tonsillectomy last May up in Lake County
8 where we live and there are no ASTC options for him
9 there and we did go to Children's, but I was seeking
10 out an ASTC option because of my experience between
11 the two sites of service.

12 DR. BURDEN: I won't waste everybody's time,
13 but I spent 15 years looking at all the alleged
14 malpractice in the State of Illinois and we had some
15 incidents in pediatric anesthesia. I'm not
16 commenting beyond that. That doesn't mean anything
17 regarding what you said. It was just that statement
18 that no one else particularly cares. If my kid gets
19 anesthesia, I want to have a board certified
20 pediatric anesthesiologist. The surgeon is not
21 important. What is important is who's putting that
22 kid asleep and waking him up. That's me.

23 MS. OLSON: Mr. Chairman, can I just for
24 clarification.

1 CHAIRMAN GALASSIE: Yes.

2 MS. OLSON: So these three facilities that
3 are not at capacity in Table 4 are three hospitals,
4 right? So when we're losing 400 patients to Iowa,
5 it's because they are looking for an ASCT to go to.

6 MR. MOVVA: That's correct. None of those
7 patients are being done because there is no facility
8 for ENT procedures, urology procedures, gynecologic
9 procedures, some podiatry procedures, ophthalmology
10 procedures.

11 One example is we have urologists that are
12 in our office park. They share our parking lot with
13 us. They see patients -- I'm not born here but I
14 was raised since the age of two in Illinois. You
15 know, I trained here, came back to practice in my
16 community where I grew up, and it's very
17 disconcerting to see, you know, patients and doctors
18 having to leave the state and go practice other
19 places. They are taking patients that we see. I
20 refer sometimes as a GI physician we do a lot with
21 reflux and sometimes that crosses over in ENT.
22 Those patients then get seen in an office in
23 Illinois, across the street from you, but then when
24 it comes to having their procedure done, they are

1 taken out of state and taken to those ASCs in Iowa
2 where they can be done.

3 MS. OLSON: Because of the cost?

4 MR. MOVVA: Because of the costs, but at the
5 same time, none of those centers accept Illinois
6 Medicaid. They accept Iowa Medicaid, but they don't
7 accept Illinois Medicaid, so Illinois Medicaid
8 patients, which we accept completely in our center
9 have been completely shut out of this availability
10 of having services in these different specialties,
11 and especially in fields especially like gynecology
12 we're losing these providers to the other side of
13 the river, into the Iowa side because, frankly,
14 their malpractice structure is different and because
15 of this ability to have patients is very difficult
16 for them to keep separate offices on both sides and
17 keep it running.

18 MS. OLSON: That's a significant cost
19 savings.

20 MR. MOVVA: Absolutely.

21 CHAIRMAN GALASSIE: Other questions from the
22 board?

23 MR. SEWELL: So these patients that are
24 going to Iowa are going to achieve a cost savings

1 because of the difference in payment policies in
2 Iowa versus Illinois. So when your service comes on
3 line, that situation remains.

4 MR. MOVVA: It is slightly different than
5 that in that the difference is that they would be
6 paying a hospital rate which is double,
7 approximately, and --

8 MR. SEWELL: It's a site thing.

9 MR. MOVVA: Yes, it's a site thing, and so
10 we would be saving money for the patient in that
11 respect, between those two. That's why they're
12 going to Iowa.

13 MR. SEWELL: I'm somehow not able to
14 reconcile that with the failure of this
15 application -- excuse me, I'm trying to find what
16 I'm looking for -- to meet the occupancy targets.
17 Are these occupancy targets just for ambulatory
18 surgery and treatment facilities or for everybody
19 doing surgery?

20 MR. CONSTANTINO: The hospitals and ASCTs
21 within the identified geographic service area.

22 MS. FRIEDMAN: One of the things that is not
23 identified in this Regional Surgi Center is not on
24 this table and it has capacity also.

1 CHAIRMAN GALASSIE: Other questions by board
2 members?

3 MR. URSO: I just want to make a comment to
4 the board members that there was some discussion
5 here from the applicants that they wanted to
6 restrict your ability to add a condition on this
7 particular permit. I think you have a right to do
8 that and, if you so desire, we could add a
9 condition.

10 One condition that they were hoping you
11 would not add has to do with adding additional
12 surgical specialties that they would have to come
13 back before this Board before they did that. I just
14 want the Board to know that it's up to them if they
15 choose to add a condition on this particular
16 application.

17 MS. OLSON: I thought the condition already
18 existed.

19 MR. CONSTANTINO: It does. That's why
20 they're here today.

21 MR. URSO: It already exists with this
22 applicant.

23 MR. CONSTANTINO: Right, yes.

24 MR. SEWELL: So let me understand something.

1 I think the applicant wants not only approval of the
2 application, but they want to remove this
3 restriction, two things they want.

4 MR. CONSTANTINO: That's correct.

5 MR. SEWELL: Okay. Well, probably our first
6 motion will just be on the application. Is that
7 what we're going to do?

8 CHAIRMAN GALASSIE: We can. Or a motion
9 with a condition. Okay. Will you entertain a
10 motion to approve Project 11-101 for the addition of
11 a surgical specialty to a multi-specialty ASTC in
12 Moline, Illinois.

13 MR. HILGENBRINK: So moved.

14 MR. GREIMAN: Seconded.

15 CHAIRMAN GALASSIE: Moved and seconded.

16 MR. ROATE: Motion made by Mr. Hilgenbrink,
17 seconded by Mr. Greiman.

18 Dr. Burden?

19 MR. BURDEN: Yes.

20 MR. ROATE: Mr. Eaker?

21 MR. EAKER: Yes.

22 MR. ROATE: Mr. Greiman?

23 MR. GREIMAN: Yes.

24 MR. ROATE: Mr. Hayes?

1 MR. HAYES: Yes.

2 MR. ROATE: Mr. Hilgenbrink?

3 MR. HILGENBRINK: Yes.

4 MR. ROATE: Ms. Olson?

5 MS. OLSON: Yes.

6 MR. ROATE: Mr. Sewell?

7 MR. SEWELL: Yes.

8 MR. ROATE: Chairman Galassie?

9 CHAIRMAN GALASSIE: Yes. Motion passes.

10 Congratulations.

11 Now I need some clarity on another motion
12 that you're suggesting, and am I hearing that this
13 will be a motion that the applicant would be
14 required to come back to this board for the addition
15 of any additional specialty? Is that what was on
16 the table?

17 MS. OLSON: Doesn't that already exist?

18 MR. CONSTANTINO: Yes, they have to.

19 MS. OLSON: So the motion would be to remove
20 that.

21 CHAIRMAN GALASSIE: You're right. Is there
22 a desire by the board to present a motion to remove
23 that requirement of this applicant having to come
24 back for the addition of yet another specialty?

1 MR. SEWELL: I don't want to go too much
2 into this, but why did we put this restriction on in
3 the first place for this applicant?

4 MS. FRIEDMAN: I was there, and I'll tell
5 you there was really no dialogue.

6 CHAIRMAN GALASSIE: I'm actually going to
7 ask Mike to answer that.

8 MR. CONSTANTINO: Generally the feeling is
9 that because most of the ASTCs do not provide
10 charity care and Medicaid, that they should not have
11 the ability to just add services without coming back
12 before the Board. There are other ASTCs that have
13 the same stipulation that you put on it. RGS or
14 Regional Surgi Center is not alone here and I
15 believe this was challenged in court, if I'm not
16 mistaken. Is that correct, Frank?

17 MR. URSO: We just had a case.

18 MR. CONSTANTINO: The outcome?

19 MR. URSO: It was dismissed on other grounds
20 so they didn't go into the merits of the case.

21 MS. OLSON: But you said for many of the
22 other surgery centers it's basically that they do
23 take Medicaid where this surgery center does take
24 it?

1 MR. CONSTANTINO: Yes, but the figures
2 they're telling you do not coincide with what's been
3 reported to us. They are saying seven and a half
4 percent. We are not seeing that. That's not being
5 reported to us. We have 2010 information. I don't
6 know what they're reporting.

7 MS. FRIEDMAN: There is a typo in this state
8 agency --

9 CHAIRMAN GALASSIE: A board member was
10 talking.

11 MS. FRIEDMAN: I'm sorry, Ms. Olson.

12 MS. OLSON: That's okay. Go ahead.

13 MS. FRIEDMAN: I was just going to say there
14 is a typo in the state agency report for the 2010
15 Medicaid patient data, but if you look at your
16 hospital profile, it's on page 253 and 254 of the
17 ASCT profile, there is 741 Medicaid cases provided
18 by this provider in the last reported year.

19 DR. BURDEN: Mr. Chairman, can I respond to
20 that?

21 MR. CONSTANTINO: 2.8 percent of Medicaid
22 revenue as a percentage of revenue is what was
23 reported to us in 2010.

24 DR. BURDEN: My experience is, and I would

1 not hesitate to listen to what other board members
2 say is exactly what you said. On this particular
3 ambulatory surgical is now multi special clinic, I
4 made that comment. In my experience I've had more
5 than one ASCT show up here where they came surprised
6 that I requested that they, at least, apply for
7 Medicaid, so I for one would be opposed to just
8 unilaterally allowing -- individually on this
9 particular application, I agree that I see no reason
10 for them. They have shown, in my opportunity to
11 treat all comers and that is my feeling on the
12 matter and I don't know how anybody else feels.

13 CHAIRMAN GALASSIE: I have not heard anyone
14 proposing a motion, thus I --

15 MS. OLSON: I would like to propose a motion
16 to remove the restriction based on the fact that
17 they are a facility, an ASTC that is willing to see
18 Medicaid patients.

19 CHAIRMAN GALASSIE: We have a motion. Is
20 there a second?

21 DR. BURDEN: Yes.

22 MR. ROATE: Motion made by Ms. Olson,
23 seconded by Dr. Burden.

24 Dr. Burden?

1 MR. BURDEN: Yes. I'm voting specifically
2 for the Regional Surgi Center, correct?

3 CHAIRMAN GALASSIE: That's right.

4 MS. BURMAN: Yes.

5 MR. ROATE: Mr. Eaker?

6 MR. EAKER: No.

7 MR. ROATE: Justice Greiman?

8 MR. GREIMAN: Yes.

9 MR. ROATE: Mr. Hayes?

10 MR. HAYES: No, because another reason for
11 this is to be able to protect the surgeries in
12 hospitals and that is a major reason why these
13 restrictions are put on, so I vote no.

14 MR. ROATE: Mr. Hilgenbrink?

15 MR. HILGENBRINK: I vote no for similar
16 reasons.

17 MR. ROATE: Ms. Olson?

18 MS. OLSON: I vote yes because the cost
19 savings to the patients and I believe it's a rare
20 entity in a multi surgery center that takes
21 Medicaid.

22 MR. ROATE: Mr. Sewell?

23 MR. SEWELL: I vote yes.

24 MR. ROATE: Chairman Galassie?

1 CHAIRMAN GALASSIE: I vote yes.

2 MR. ROATE: Five votes in the affirmative,
3 three votes in the negative.

4 CHAIRMAN GALASSIE: Motion passes.
5 Congratulations and good luck to you.

6 Moving on to item Project 11-115, Metro
7 Self Medical Center. Any public comment on this?

8 MR. MORADO: No.

9 CHAIRMAN GALASSIE: Hearing none, if folks
10 from Metro would come to the table and kindly state
11 your names and spell them for our reporter, please.

12 MR. MILLER: Tom Miller, T-O-M, M-I-L-L-E-R.

13 MR. KRULE: Laurence Krule, K-R-U-L-E.

14 MR. BECKMANN: Enrique Beckmann,
15 E-N-R-I-Q-U-E, B-E-C-K-M-A-N-N.

16 MS. RANALLI: Clare Ranalli.

17 CHAIRMAN GALASSIE: Thank you, folks.

18 Can we have a collective swearing in,
19 please.

20 (ALL WITNESSES SWORN)

21 CHAIRMAN GALASSIE: Thank you.

22 And the staff report.

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

24 Community Health Systems in proposing to purchase

1 Metro South, a 330 bed acute care hospital in Blue
2 Island, at a cost of approximately \$50 million. The
3 applicants have met all of the requirements of the
4 state board regarding this change of ownership. The
5 state board notes the following. No public hearing
6 was requested and no letters of support or
7 opposition were received by the state board staff.
8 Thank you, Mr. Chairman.

9 CHAIRMAN GALASSIE: Thank you for that
10 report. I will ask who would like to speak to the
11 board.

12 MR. MILLER: Thank you, good afternoon. My
13 name is Tom Miller. I'm a Division President with
14 Community Health System Professional Service
15 Corporation responsible for the hospitals in
16 Illinois, Indiana, Missouri, Kentucky, Ohio and West
17 Virginia. In Illinois we have seven Community
18 Health System affiliated hospitals, which include
19 Vista Medical Center, Red Bud Regional Hospital,
20 Union County Hospital, Heartland Regional Medical
21 Center, Crossroads Community Hospital, Gateway
22 Regional Medical Center and Galesburg Cottage
23 Hospital. We have a solid track record providing
24 quality care for Illinois communities for almost 20

1 years and have provided safety net services in each
2 of the communities served by our hospitals, three of
3 which provide more than 20 percent of the total care
4 to Medicaid patients.

5 Our hospitals operate with a core
6 philosophy of creating great places for patients to
7 receive care, for physicians to practice and for
8 people to work. We are dedicated to providing
9 personalized, compassionate and efficient care to
10 our patients with total satisfaction as our top
11 priority.

12 We are a national leader in quality
13 services and have been recognized nationally for the
14 care we provide. On a combined basis, our
15 affiliated hospitals have achieved 19 consecutive
16 quarters and improvements in a CMS inpatient core
17 pressures quality scores. Recently the Joint
18 Commission recognized 405 hospitals as the top
19 providers of key quality measures, 41 of these were
20 CHS affiliated hospitals.

21 Additionally, Press Ganey, a national
22 leader in satisfaction measures recognized just 11
23 hospitals in the country with a summit award for
24 clinical core measures, 11 of these were CHS

1 hospitals, excuse me -- eight of the 11 were CHS
2 hospitals. We are proud of these accomplishments
3 and our performance speaks for itself. We invest in
4 our hospitals to insure that we meet the government
5 rules and regulations and operate our facilities in
6 accordance with the highest standards in our
7 community.

8 Our commitment to the community is best
9 demonstrated by our history. In 2011 we provided
10 \$48 million in charity care while also paying
11 \$7.8 million in Illinois taxes. We are one of major
12 employers in every community we serve and our
13 commitment to being a great corporate citizen is
14 demonstrated through our involvement in community
15 boards, sponsorships of community organizations and
16 leadership and economic development activities. Our
17 success is due to our ability to dedicate financial
18 resources, apply proven best practices and exhibit a
19 commitment to improvement in everything that we do
20 in our local hospitals.

21 We have demonstrated over the years that
22 we take good hospitals and make them better. This
23 is our intent at Metro South and is demonstrated
24 every day in all seven of our hospitals in the

1 state.

2 In summary, I hope you approve the change
3 in ownership of Metro South Medical Center. It has
4 been serving the Blue Island community for over a
5 hundred years. We look forward to helping it do so
6 well into the future.

7 It is with great optimism that we look to
8 this future and our role in it. With that, I would
9 like to introduce Larry Krule, the Chief
10 Restructuring Officer at Metro South.

11 MR. KRULE: Thank you. Good afternoon. My
12 name is Laurence Krule. I'm the Chief Restructuring
13 Officer of MSMC Investors, the organization that
14 acquired Metro South Medical Center in 2008 from SSM
15 Healthcare.

16 Some of you may have been on the board at
17 that time. You may recall that St. Francis Hospital
18 and Health Center, which has served Blue Island and
19 surrounding communities for 103 years has suffered
20 significant losses over several years. Ultimately,
21 SSM determined that they were unable to sustain the
22 hospital's operations and decided to sell the
23 hospital.

24 SSM engaged in a significant process to

1 find the strategic or financial buyer, but were
2 unsuccessful. They were about to close its doors.
3 They issued warrant act notices to its employees
4 when we reached out to them and commenced
5 discussions that led to the acquisition in July of
6 2008.

7 I am pleased to sit before you today and
8 to report that we have not only continued to serve
9 the Blue Island community, but have made substantial
10 capital and facility investments which were
11 desperately needed. These included significant
12 enhancements of the emergency departments ER fast
13 track and electronic medical records, house wide
14 resulting in reduced wait time to patients.
15 Additional enhancements included stroke,
16 telemedicine 2/47 in collaboration with Rush
17 University, pharmacy drug dispensers in the ICR, 16
18 slide CT scanner and digital mammography.

19 The implementation of electronic medical
20 records in physicians offices are well under way,
21 thereby providing physicians immediate access to
22 patient diagnostic testing results.

23 We engaged in various efforts to enhance
24 and efficiently streamline processes without

1 compromising quality of care and remain the largest
2 employer in the area with over 1200 employees. We
3 have held our commitment to you that we would
4 maintain admissions and charity care policies that
5 St. Francis Hospital had in place at the time.

6 We are confident that CHS will continue to
7 serve the community in a similar manner and are very
8 pleased that it will be subject to your approval
9 taking over the reins of Metro South Medical Center.

10 CHS has proven itself willing and able to
11 provide safety net services to its two locations in
12 Waukegan and also is committed to those in need of
13 behavioral and rural health services in Illinois.

14 Thank you for your time. I would like to
15 turn things over to Dr. Beckmann now to describe the
16 vibrant quality services that he and all of those
17 who work that MSMC provide. Thank you.

18 CHAIRMAN GALASSIE: Thank you.

19 DR. BECKMANN: Good afternoon. I am
20 Dr. Enrique Beckmann, and I am the Chief Executive
21 Officer and Chief Medical Officer at Metro South
22 Medical Center in Blue Island. I have been the
23 Chief Medical Officer for three and a half years
24 since St. Francis was acquired from SSM, and one

1 year after the acquisition I also became the Chief
2 Executive Officer. Going forward I will remain a
3 CEO and CMO under CHS's ownership pending your
4 approval.

5 As a physician hospital administrator, I
6 strive to impact positively the health of our
7 community. My focus has been and will continue to
8 be improvement in number one, access to care through
9 expanded outpatient services and programs,
10 marketing, community outreach and off site clinics.

11 Number two, the quality and
12 appropriateness of medical care through the use of
13 outcome data and surveys of the various
14 constituencies that we serve, patients, physicians
15 and employees.

16 Number three, communication, among
17 providers and between providers and patients through
18 appropriate information, technology and automation.

19 Number four, diagnostic and therapeutic
20 capabilities through the recruitment of qualified
21 providers and investment in state of the art
22 technology.

23 Number five, patient satisfaction through
24 capital investment and physical plant modernization

1 and upgrades.

2 Number six, clinical, as well as
3 nonclinical operations through recruitment and
4 retention of high quality management teams.

5 Number seven, patient safety through the
6 use of modern technology, analysis of aggregate
7 data, provider and patient education, fostering a
8 blameless and open culture and appropriate staffing.

9 In the future working with CHS I
10 anticipate continuing to move things forward. With
11 the enhanced capital and management resources that
12 CHS brings, MSMC will increase the size and scope of
13 among others, its programs in emergency care,
14 geriatrics, orthopedics, surgery, cardiology and
15 obstetrics and gynecology. We will modernize our
16 physical plant and make it more patient friendly.
17 We will recruit new primary care physicians and
18 specialists and we will invest in modern information
19 and medical technology.

20 The timeline for achieving these goals
21 will be defined shortly after the transfer of
22 ownership following the conclusion of a strategic
23 plan defined through the participations of various
24 constituencies and modulated by capital and other

1 considerations.

2 I look forward to being the CEO/CMO of
3 Metro South Medical Center in the CHS family. In my
4 discussions with CHS as part of the transition
5 process and through my participation in the very
6 thorough due diligence activities leading up to
7 today, where I had the opportunity to interact very
8 meaningfully with many of the excellent, experienced
9 and talent experts from the corporation, I am
10 comfortable that they share my objectives of
11 continuing to provide quality care and service to
12 the Blue Island and surrounding communities.

13 I firmly believe that we will be in the
14 best position to take the hospital to a new high.
15 The integration of the existing management team,
16 which will remain essentially intact into the CHS
17 structure, should be seamless and mutually
18 enhancing.

19 And I would like to also add finally that
20 there is a great deal of anticipation at the medical
21 center as we are appearing in front of this board in
22 a great deal of expectation for a satisfactory
23 outcome on the part of the employees and physicians
24 of the hospital. Thank you very much.

1 CHAIRMAN GALASSIE: Thank you, Doctor. I
2 would like to open it up to board members for
3 questions.

4 DR. BURDEN: Dr. Beckmann, I know what
5 you're attempting to do, but I want to make sure
6 that the hospital profile as I see it is accurate.
7 CON beds as of December were 272 but you actually
8 function with 94 beds; is that correct?

9 DR. BECKMANN: Functioning with 94 beds?

10 DR. BURDEN: For your peak beds for your
11 peak census was 85 beds according to what I have in
12 front of me. Am I correct? I'm just asking you.

13 DR. BECKMANN: Our average daily census is
14 119.

15 DR. BURDEN: So this should be corrected
16 somewhat. On the basis of what I see in your
17 hospital profile, 33 percent occupancy as med-surge
18 beds, to me, spells disaster in terms of turning
19 things around. I mean, unless you're making other
20 changes, that's incorrect?

21 DR. BECKMANN: Dr. Burden, you are referring
22 to med-surge beds, and there is also a significant
23 obstetrician capability at the hospital so you are
24 just looking at the med-surge beds.

1 DR. BURDEN: Well, that is pretty low. I'm
2 not saying that it isn't a number that we see
3 occasionally, but you're talking about turnaround
4 and that's one of the first things I look at which
5 as a practitioner that sort of distressed me in
6 terms of coming to work at your hospital.

7 Off the record, I'm sure that you can do a
8 marvelous job of recruitment, but why is the census
9 so low? OB, that's acceptable. I don't understand,
10 do you farm out all radiation? There's no evidence
11 you own any radiation equipment. Is there a reason?

12 DR. BECKMANN: We lease space to a radiation
13 oncology group that is housed in the medical office
14 building across the street from us and they provide
15 radiation.

16 DR. BURDEN: You don't own the equipment.

17 DR. BECKMANN: We don't own the equipment.
18 We lease the the space and there is a private
19 provider who provides the radiation oncology.

20 DR. BURDEN: What changes would you say you
21 currently -- what changes have occurred since the
22 the sale? I was here.

23 MR. BECKMANN: I know you were.

24 DR. BURDEN: And I'm anxious to see.

1 Obviously, we see a lot of applications. Is the
2 data that I'm seeing in front of me comparable to
3 what it was three years ago, three and a half or is
4 it worse or better?

5 DR. BECKMANN: Well, let me comment on a
6 couple of things you have said and answer your
7 question.

8 First of all, in terms of the volumes at
9 the hospital, as you know, since you're a physician
10 and you've been in this community for a long time,
11 there is a great shift between inpatient to
12 outpatient and we've seen a dramatic growth in
13 outpatient activity in the hospital from the time
14 that it was St. Francis to where it is now. I'd say
15 in the aggregate and I'm quoting from memory, we've
16 increased our outpatient volumes by about 40 percent
17 compared to where St. Francis was. From an
18 inpatient point of view, there has been a decrease
19 and that is a nation wide phenomena as you know. I
20 think we've experienced maybe a 2 and a half to
21 3 percent decrease every year so we've been there
22 for about four years so we've seen a decrease in
23 inpatient activity.

24 The most incredibly positive things that

1 we've achieved at the hospital, for which I am
2 particularly pleased, when we got there, the
3 hospital did not really have an outreach program.
4 They did not have a presence outside of the
5 hospital's four walls in the community. There were
6 no outpatient centers scattered in the community and
7 the surrounding communities. We have put 11 of
8 those centers since we started. That's actually
9 created tremendous availability of our services to
10 the community which has created, of course, a better
11 situation for access to care and I'm happy to say
12 also that in those outpatient centers we see
13 anywhere from 25 to about 75 percent Medicaid
14 patients.

15 As you know, it is a community in many of
16 the areas surrounding the hospital. So that has
17 been one of the biggest assets, but I have to also
18 say a remarkable achievement of ours is this is a
19 small hospital serving a small community that is
20 challenged in many respects and, in spite of that,
21 we are able to implement an electronic medical
22 record that is second to none. We have a truly
23 paperless system in the hospital. We have
24 100 percent of our units on an electronic medical

1 record and the impact of that, I'm sure it doesn't
2 escape you, has been tremendous from the standpoint
3 of improvements in quality, both documentation and
4 compliance with all requirements.

5 DR. BURDEN: I'll state categorically I
6 wouldn't apply for your status on that basis alone.
7 I'm a computer nerd, but my grandkids can but I
8 can't. I wanted to state. My fellow colleague on
9 the board is somewhat critical of my feelings toward
10 health care reform, let's call it that. How can you
11 look forward to the Supreme Court saying, okay, go
12 forward. Do you look forward enthusiastically or
13 with some reservation?

14 DR. BECKMANN: Are you asking my personal
15 opinion?

16 DR. BURDEN: Of course.

17 MR. BECKMANN: I will not share my personal
18 opinion.

19 MR. MILLER: I will answer that if you
20 like. From a health care industry, I think every
21 hospital has initially supported the existing plan
22 in the belief that you have to come to the
23 conclusion whether health care is a right or not and
24 many people in this country see it as a right to

1 health care and being able to have 94, 95, 96
2 percent covered under some form of insurance
3 shouldn't prove access to care and that is just a
4 health care viewpoint that most of our hospitals
5 have.

6 DR. BURDEN: My argument is not health care,
7 it is insurance reform. That's what I maintain
8 always, and I don't see any change in what you said
9 and I don't disagree. My kids are adamant about it.
10 All younger people are, but I share some reluctance
11 about what we will see.

12 MR. MILLER: I'm not sure the existing
13 plan was a health care reform insurance plan
14 legislation. I think it was meant to really give
15 access to everyone to basic level of care.

16 DR. BURDEN: I don't disagree access should
17 need to be improved period. That's all.

18 MR. EAKER: I would like to ask a question
19 about the state monitoring for life safety issues
20 and the termination of Medicare. Are those things
21 being addressed and can you address them?

22 DR. BECKMANN: The life safety issues at the
23 hospital?

24 MR. EAKER: Yes.

1 DR. BECKMANN: Frankly, all the issues that
2 have been brought to the hospital have been either
3 addressed or in the process of being addressed and
4 we are working very closely with the state to
5 resolve whatever outstanding issues there are.

6 MR. CONSTANTINO: Mr. Eaker, they are still
7 under state monitoring.

8 MR. HAYES: In the acquisition of this
9 St. Francis Hospital in 2008, could you describe
10 that acquisition, the fair market value and then the
11 funds that were used and how was that cash that
12 changed hands, the cash that changed hands between
13 the Sisters and then the hospital itself and the
14 investments that were made.

15 MR. KRULE: I can go through that for you.
16 At the time of the transaction, the Sisters of
17 St. Mary, SSM provided \$9.6 million for working
18 capital. In addition, the investor group
19 contributed \$2 million. The investor group also
20 arranged for financing for the 2.5 million dollars
21 of debt financing, long term debt and/or immediate
22 term debt actually and 15 million dollars. That
23 totals \$31.8 million of essentially capitalization
24 at risk at that time. And during the time of the

1 ownership, we've done a number of investments both
2 capital expenditure and otherwise, but a total of
3 \$18 million was spent specifically for capital
4 expenditure over the course of the three and a half
5 years.

6 MR. HAYES: So what would be -- so basically
7 if you're looking at this transaction and you are
8 basically -- how much are you receiving then from
9 Community Health?

10 MR. KRULE: To start, and again, I think all
11 of this information is included here. There is a
12 40 million-dollar purchase price, there is an
13 adjustment even at the point of closing for network
14 and capital adjustment, which is actually negative,
15 so there is \$38.6 million available in closing.

16 That money is then allocated to a number
17 of other items at closing. The net result of which
18 is that about \$12 million will go to the investors
19 at that time and the rest of it, let me just make
20 sure, the rest of that money is as follows: There is
21 \$14 million of insurance, general liability and
22 professional liability required for us to buy at
23 closing; \$6 million is being escrowed for any number
24 of contingencies that may happen over the next few

1 years; \$6 million is the net bank debt that gets to
2 be repaid at closing also; \$2 million in taxes will
3 be paid and there is about a million dollars on our
4 side, a million and a half dollars on our side for
5 closing costs so the net is around 11 to
6 \$12 million.

7 MR. HAYES: And that is the return to the
8 investor group?

9 MR. KRULE: That's a net.

10 MR. HAYES: Basically, during your time
11 here, I think in January of 2010, I think you've
12 come back and have done some other projects to be
13 able to revise the amount of mental health
14 facilities and mental health beds. Am I right on
15 that?

16 DR. BECKMANN: We do not have any patient
17 mental health capability at Metro South. What we
18 came back for, if you probably remember this. We
19 came back to the state because we wanted to be
20 decertified for pediatrics. We had found ourselves
21 in a situation where our average daily census in
22 pediatrics was less than one and we couldn't really
23 retain the talent and quality that we required in
24 order to maintain that capability. We continue to

1 provide neonatology services in outpatient
2 pediatrics, but we don't have inpatient pediatrics.
3 We have referral agreements with two local
4 providers.

5 MR. HAYES: So, essentially, on this real
6 estate flip here, I think that, from our original
7 application, we thought that perhaps over
8 \$20 million was going to go for capital expenditures
9 into this project, but from your description there,
10 I think you were talking about debt and assuming
11 debt and a line of credit so that \$20 million,
12 besides the working capital and the \$3 million in
13 fees, that never materialized, is that correct?

14 CHAIRMAN GALASSIE: I think it was about
15 40 million.

16 MR. KRULE: I'm confused with the numbers
17 you provided, but over \$18 million was directly
18 spent on capital expenditure. In addition, there
19 was \$20 million of capital, working capital provided
20 which was at risk during the entire ownership. In
21 fact, there were points in time where we did not
22 know whether we would actually have that returned or
23 whether capitalizations would be required so the
24 turn around itself, although now we are very pleased

1 with the state of the success, it was a risk during
2 this period of time. All the capital I described
3 was \$32 million.

4 MR. HAYES: But the 20 million, you received
5 9.6 of that from the Sisters, is that correct?

6 MR. KRULE: Correct.

7 MR. HAYES: Is this hospital profitable
8 today?

9 MR. KRULE: The short answer is yes we are
10 positive.

11 MR. HAYES: But what about bottom line
12 before taxes?

13 DR. BECKMANN: Yes.

14 MR. KRULE: Yes.

15 MR. HAYES: Now, so basically for the
16 investment for two years, the investor group is
17 receiving about \$12 million in their return.

18 MR. KRULE: It's nearly four years.

19 MR. HAYES: So that's about \$3 million a
20 year.

21 CHAIRMAN GALASSIE: He said he was pleased
22 with the outcome, as you should be and as you have a
23 right to be. But it also is part of our role to
24 look at the economics of this issue and clearly SSM

1 has fortunately done well. Had we been sitting here
2 or if we sit back here in 2008 the Archdiocese was
3 very happy to see them come to the table and as well
4 as employment to the community I'm very familiar
5 with the hospital.

6 MR. KRULE: If I could just remind you that,
7 at the time of the acquisition, the notices had been
8 issued, but SSM actually was holding job fairs in
9 the hospital and invited other neighboring hospitals
10 in to hire the employees. That may or may not have
11 been successful. So the savings of the turn around
12 of the hospital is very important to the 1,200
13 employees and to the surrounding community of Blue
14 Island which was the largest employer.

15 CHAIRMAN GALASSIE: I'm just wondering why
16 you would interrupt when you are being complimented.

17 Are there any other questions on the
18 behalf of the board members?

19 I am going to propose a motion to approve
20 Project 11-115 for change of ownership of Metro
21 South Medical Center in Blue Island, Illinois.

22 DR. BURDEN: So moved.

23 MR. SEWELL: Second.

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

1 seconded by Mr. Sewell.

2 CHAIRMAN GALASSIE: Roll call.

3 MR. ROATE: Dr. Burden?

4 DR. BURDEN: Yes.

5 MR. ROATE: Mr. Eaker?

6 MR. EAKER: Yes.

7 MR. ROATE: Judge Greiman?

8 MR. GREIMAN: Yes.

9 MR. ROATE: Mr. Hayes?

10 MR. HAYES: Yes.

11 MR. ROATE: Mr. Hilgenbrink?

12 MR. HILGENBRINK: Yes.

13 MR. ROATE: Ms. Olson?

14 MS. OLSON: Yes.

15 MR. ROATE: Mr. Sewell?

16 MR. SEWELL: Yes.

17 MR. ROATE: Chairman Galassie?

18 CHAIRMAN GALASSIE: A congratulatory yes.

19 Moving on to item 11-116, Vista Surgery
20 Center. We will entertain representatives of Vista
21 Surgery Center to come to the table and introduce
22 yourselves, spell your name for the reporter and we
23 will swear you in. Barbara Martin, M-A-R-T-I-N.

24 (WITNESS IS SWORN.)

1 CHAIRMAN GALASSIE: Welcome, Barb. I had
2 the pleasure of working with Ms. Martin for several
3 years in Lake County and Vista was an active and is
4 an active member of several community
5 collaborations. It is pleasure to see you again.

6 MS. MARTIN: Thank you.

7 CHAIRMAN GALASSIE: Mike, can we have a
8 staff report.

9 MR. CONSTANTINO: The applicants are
10 proposing a change of ownership of a multi-specialty
11 ASTC. This is a corporate restructuring to allow
12 for a physician investment in the LLC. Waukegan
13 Hospital of Illinois will retain a 51 percent
14 ownership in the ASTC. We note no public hearing
15 was requested and no letters of support or
16 opposition were received. Thank you.

17 CHAIRMAN GALASSIE: Thank you. Ms. Martin.

18 MS. MARTIN: Thank you, Chairman. Vista
19 Health System, so you all know, the owner of Vista
20 Surgery Center is a system of two hospitals located
21 in Waukegan, Illinois and we also have several
22 ambulatory care sites throughout Lake County.

23 Vista Surgery Center has been operational
24 for about 15 years and has been owned by Community

1 Health System for just about six years which will
2 occur in July of 2012. Vista will continue to
3 maintain majority ownership of the surgery center at
4 51 percent ownership where surgeon investors will
5 earn 49 percent of the ownership.

6 As many of the board members know from
7 past and many appearances in front of this planning
8 board, Vista Health System is the safety net system
9 or hospital located in Waukegan of Lake County
10 without a doubt and still continue to be.

11 With partnering with the physicians we
12 believe and the physicians approached Vista. We
13 work well with them, but we believe that partnering
14 with them will help really provide access to care in
15 the western part of the county, will also allow us
16 to certainly decrease costs because we will be
17 moving from a hospital base surgery center to a
18 free-standing emergency center where the costs are
19 certainly cheaper and also it will help give Vista a
20 shot in the arm. We have had an ambulatory care
21 center at that site along with our surgery center
22 for 15 years also. That part of the county is
23 growing and there is need for access to health care
24 and this will provide much better access to

1 outpatient surgery, et cetera, to patients, to
2 doctors and the community.

3 We also believe that we will continue on
4 this process. We will continue to provide the same
5 charity care, self pay and bad debt policies that we
6 have at the hospital currently and I will say again
7 we are the safety net providers. So with this, we
8 would ask if you have any questions and thank you
9 for allowing us to present this project.

10 CHAIRMAN GALASSIE: Thank you. Questions
11 from the board? I would be remiss myself as having
12 spent 30 years of my life in Lake County as health
13 officer, 20 at least in that role. Vista clearly is
14 the provider of the individuals who are underserved
15 and underinsured and uninsured in Lake County and I
16 think I would at least want to comment as well it
17 was with great trepidation on my part the community
18 concerned about a for profit ownership out of state,
19 some of that to our ignorance truthfully, but it has
20 been a wonderful addition to Lake County. It would
21 be in very serious condition without them. That
22 having been said, other questions, please.

23 MR. HAYES: Have you looked into the Stark
24 information as well as the Health Care Worker Self

1 Referral Act in Illinois. Does this transaction
2 which will give ownership to physicians, I think
3 that is why you are making this transaction, will
4 that have any effect on it?

5 MS. MARTIN: We certainly have had great
6 legal review related to this. We are in full
7 compliance with Stark which is self referral. Also,
8 this facility will act under the Safe Harbor Law
9 also with physicians that watch very closely their
10 referrals, et cetera. Certainly, it is fully in
11 compliance with all laws both Federal and State of
12 Illinois.

13 MR. HAYES: And you are in compliance with
14 Safe Harbor on Stark?

15 MS. MARTIN: Yes, absolutely.

16 MR. HAYES: Can you give us a little bit of
17 background. Why are you in -- why do you qualify
18 for Safe Harbor there?

19 MS. MARTIN: Well, the one thing that Stark
20 still allows hospitals to partner with is with
21 syndication of surgery centers in Illinois and
22 Illinois is very restrictive. Illinois still allows
23 syndication of surgery centers with physicians,
24 surgeons, only surgeons. So with that, the doctors

1 came to Vista. We were underutilized, sorely
2 underutilized as a facility. It is a beautiful
3 facility and asked us to partner with them. We have
4 strong relationships with them. So with that, for
5 about a year worked on all the laws, had legal ends
6 from both sides of the practice and, you know, a
7 community health system is very conservative in any
8 type of risk. They take essentially none, and this
9 clearly complies with Stark, Safe Harbor and all.

10 MR. HAYES: Thank you.

11 CHAIRMAN GALASSIE: Other questions by board
12 members?

13 (NO RESPONSE)

14 CHAIRMAN GALASSIE: Hearing none, may I have
15 a motion to approve Project 11-116 for change of
16 ownership of Vista Surgery Center in Lindenhurst,
17 Illinois.

18 MR. SEWELL: So moved.

19 MR. GREIMAN: Second.

20 CHAIRMAN GALASSIE: Moved and seconded.

21 Roll call, please.

22 MR. ROATE: Motion made by Mr. Sewell,
23 seconded by Justice Greiman. Dr. Burden?

24 DR. BURDEN: Yes.

1 MR. ROATE: Mr. Eaker?

2 MR. EAKER: Yes.

3 MR. ROATE: Judge Greiman?

4 MR. GREIMAN: Yes.

5 MR. ROATE: Mr. Hayes?

6 MR. HAYES: Yes.

7 MR. ROATE: Mr. Hilgenbrink?

8 MR. HILGENBRINK: Yes.

9 MR. ROATE: Ms. Olson?

10 MS. OLSON: Yes.

11 MR. ROATE: Mr. Sewell?

12 MR. SEWELL: Yes.

13 MR. ROATE: Chairman Galassie?

14 CHAIRMAN GALASSIE: Yes. Motion passes.

15 Congratulations.

16 MS. MARTIN: Thank you.

17 CHAIRMAN GALASSIE: Does the board desire a

18 ten-minute break? Let's take a ten-minute break.

19 Let's be back at 3:15.

20 (A BRIEF RECESS WAS TAKEN.)

21 CHAIRMAN GALASSIE: Thank you very much for

22 being timely. We appreciate that. This is the time

23 of the day that moves on. We are now looking at

24 Project number 11-091 for Fresenius Medical Care in

1 DuQuoin. Could you introduce yourselves and spell
2 your name for our reporter, please.

3 MR. ALDERSON: Richard Alderson,
4 A-L-D-E-R-S-O-N.

5 MS. WALKER: Tara Walker, W-A-L-K-E-R.

6 MS. RANALLI: Clare Ranalli,
7 R-A-N-A-L-L-I.

8 MS. WRIGHT: Lori Wright, W-R-I-G-H-T.

9 CHAIRMAN GALASSIE: Thank you. We will do a
10 collective swearing in.

11 (WITNESSES ARE SWORN.)

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

14 MR. CONSTANTINO: Thank you, Mr. Chairman.
15 The applicants are proposing to discontinue a 10
16 station ESRD facility and establish an 11 station
17 facility in approximately 6,800 gross square feet of
18 space at a cost of approximately \$2.9 million. No
19 public hearing was requested and no letters of
20 support or opposition were received. Thank you,
21 Mr. Chairman.

22 CHAIRMAN GALASSIE: Thank you, sir. And who
23 would like to talk to the board.

24 MR. ALDERSON: I will. Thank you, sir.

1 My name is Richard Alderson, Regional Vice-President
2 of Fresenius Medical Care. With me today are Lori
3 Wright, CON Specialist, Tara Walker, Area Manager,
4 and Clare Ranalli, our legal counsel. Thank you for
5 the opportunity to be here.

6 We provide dialysis services in the rural
7 community of DuQuoin, Illinois, which has a
8 population of 6600 individuals for the past 11
9 years. Our facility is aging and outdated. There
10 are life safety concerns with the current facility.
11 We are, therefore, before you with the proposal to
12 move to a new building where we would be the only
13 tenant. We will have ample space for our home
14 therapist program and home training program.

15 Many local area residents now have to
16 travel to Carbondale for the service. We will have
17 a space to provide nocturnal dialysis and plan on
18 offering a nocturnal program.

19 Also, we will be the only provider in the
20 area to offer an isolation station for the treatment
21 of patients with Hepatitis B. We will be the only
22 provider with an isolation station within a 30
23 minute radius.

24 Isolation stations can be costly to

1 facilities because they aren't frequently utilized
2 and reimbursement isn't the same for dialysis
3 treatments as with non-isolation in-center
4 treatments. We believe offering one provides the
5 best access within our rural community.

6 The state board report was all positive
7 other than on the size of the proposed facility. If
8 you have any questions on that, we will be happy to
9 answer them. The reason we are opening a GSF
10 relates primarily to our goals to offer home
11 training and possible nocturnal, as stated in the
12 application. Thank you, again.

13 CHAIRMAN GALASSIE: Thank you. Do I hear
14 any questions from board members?

15 MS. OLSON: I just have one quick question.
16 Your lease expires in March of 2013 and your project
17 completion date is December 2013, what are you going
18 to do from March to December?

19 MR. ALDERSON: We have an option.

20 MS. OLSON: I told you that was quick.

21 CHAIRMAN GALASSIE: Yes. Hearing no other
22 questions -- hearing another question.

23 MR. SEWELL: I just wanted to say, you said
24 the reason for the lack of compliance with this is

1 no size, square footage was you had to do training?

2 MR. ALDERSON: Home therapist training.

3 MR. SEWELL: Home therapist training, and
4 that takes more room?

5 MR. ALDERSON: Well, in our current
6 facility we do not have a home therapist program.
7 They have to go to Carbondale, which is 30 minutes
8 away, so additional space will allow us to provide
9 that service in this facility

10 MR. SEWELL: And then nocturnal you said?

11 MR. ALDERSON: Yes, sir. There have been
12 a lot of studies shown that nocturnal dialysis is
13 very good for dialysis patients. In our current
14 facility we are not able to offer that and in our
15 new facility we plan on offering that as an option
16 for our patients.

17 CHAIRMAN GALASSIE: We have learned that as
18 well recently. Seeing no other questions, may I
19 have a motion to approve Project 11-091 for the
20 establishment of an 11 station ESRD facility in
21 DuQuoin, Illinois.

22 MS. OLSON: So moved.

23 MR. HILGENBRINK: Seconded.

24 CHAIRMAN GALASSIE: Moved and seconded.

1 Roll call, please.

2 MR. ROATE: So moved by Ms. Olson. Seconded
3 by Mr. Hilgenbrink. Dr. Burden?

4 DR. BURDEN: Yes.

5 MR. ROATE: Mr. Eaker?

6 MR. EAKER: Yes.

7 MR. ROATE: Justice Greiman?

8 MR. GREIMAN: Yes.

9 MR. ROATE: Mr. Hayes?

10 MR. HAYES: Yes.

11 MR. ROATE: Mr. Hilgenbrink?

12 MR. HILGENBRINK: Yes.

13 MR. ROATE: Ms. Olson?

14 MS. OLSON: Yes.

15 MR. ROATE: Mr. Sewell?

16 MR. SEWELL: Yes.

17 MR. ROATE: Chairman Galassie?

18 CHAIRMAN GALASSIE: Yes.

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

21 CHAIRMAN GALASSIE: Motion passes. Thank
22 you. Item H-11 has been deferred per review. We
23 will move on to H-12, Project 11-120 Fresenius
24 Medical Care in East Aurora. We have one public

1 comment that we will invite to the table. This is
2 opposed. Dr. Rasa Kedainis.

3 DR. KEDAINIS: Dr. Rasa Kedainis,
4 K-E-D-A-I-N-I-S.

5 CHAIRMAN GALASSIE: Thank you.

6 DR. KEDAINIS: My nams is Dr. Rasa
7 Kedainis and I am here on the behalf of Fox Valley
8 Medical Associates. I'm a nephrologist and a
9 shareholder. Thank you very much for the
10 opportunity to speak to you and provide the
11 comments.

12 I want to talk about the FMC East Aurora
13 project. The project's application attempts to mask
14 the blemishes that were fatal in its first
15 application which the board denied last year. We
16 suggest that the board step back, reevaluate this
17 project and deny it again.

18 Let me first address what this project is
19 not about. It is not about economic development for
20 Aurora, as few jobs will be created from that
21 project. It is not about projected growing demand
22 as a medically underserved area. For if that was
23 true, we would be focusing on the primary care
24 physicians and primary care services. And it is

1 also certainly not about growing patients demands by
2 the projects, the referring physician. In fact, it
3 is not about these at all. It is all about wants.

4 The project is about the largest dialysis
5 services provider in the world wanting to gain a
6 greater share of the Aurora market. To achieve that
7 end, the applicant uses the referring physician who
8 has used support of the market expansion and
9 creation of 30 additional hemodialysis stations
10 within the service area to include ten new stations
11 at FMC Aurora and an additional 12 stations at FMC
12 Batavia.

13 The referring physician claims that he
14 will refer to the project 83 patients despite the
15 fact that his practice has not shown a material
16 increase in the total number of patients for
17 in-center dialysis from 2010 to 2011 to sustain the
18 projected referrals. In those years his practice
19 grew only 2.6 percent or a total of four patients
20 from 153 to 157. The greater concern has been that
21 his practice only experienced growth of 24
22 hemodialysis patients in the last four years.
23 Therefore, while the physician might have referred
24 69 new patients last year, it is clear to me, as a

1 practicing nephrologist in this service area, that
2 the patients are simply replacing old patients who
3 have died or recovered kidney function or have
4 transplants.

5 Additionally, the proximity of FMC West
6 Chicago, U.S. Renal Care Bolingbrook and FMC
7 Naperbrook contrary to the applicant's position is
8 relevant to this project. As we have set forth in
9 our letter in opposition to the project, those
10 facilities are well within the 30 minutes travel
11 standard adopted by the board. Such travel time is
12 measured from the center of three primary zip codes,
13 60504, 60505 and 60506 that the referring physician
14 purports to refer patients to the project.

15 Collectively, there exists at least 35
16 excess ESRD stations at those three facilities.
17 Therefore, we believe that those facilities are, in
18 fact, viable alternatives for 79 out of 83 which is
19 95 percent of patients projected to be referred to
20 FMC and East Aurora.

21 And finally a review of the referring
22 physician current patient origin indicates that FMC
23 Aurora serves numerous patients living near FMC
24 Batavia and, therefore, we reasonably assume that a

1 significant portion of those patients may transfer
2 from FMC Aurora to FMC Batavia and that is allowing
3 them to accommodate those excess patients which the
4 doctor claims in that unit. And thank you very much
5 for listening to me and, for all of the reasons
6 which I mentioned, I would request the board to deny
7 the application.

8 CHAIRMAN GALASSIE: Dr. Rasa, thank you very
9 much. We will now entertain members of Fresenius.
10 Come to the table and, those who haven't been sworn
11 in, please do and introduce yourselves.

12 MS. MULDOON: Colleen Muldoon, I'm
13 Regional Vice-President for Chicago Central.

14 MS. LOWE: Jenny Lowe, L-O-W-E.

15 (WITNESSES ARE SWORN)

16 CHAIRMAN GALASSIE: Thank you. Staff
17 report, gentlemen.

18 MR. CONSTANTINO: Thank you, Mr. Chairman.
19 The applicants are proposing to establish a 12
20 station ESRD facility in East Aurora, Illinois in
21 approximately 8,500 gross square feet of space at a
22 cost of approximately \$4.4 million. We note the
23 following. This project was originally denied as
24 Project 10-086 because of an excess of 35 stations

1 in the planning area and existing facilities were
2 not operating at the target occupancy of 80 percent.
3 There was no public hearing requested, however, we
4 did receive letters of support in opposition and I
5 finally note there is an excess of 16 stations in
6 this planning area today. Five of the six stations
7 within 30 minutes are operating in excess of the
8 80 percent occupancy. Thank you, Mr. Chairman.

9 CHAIRMAN GALASSIE: Thank you. Good
10 afternoon.

11 MS. MULDOON: Good afternoon. As I said,
12 my name is Colleen Muldoon. I'm a registered nurse
13 and Regional Vice-president covering the Aurora
14 area. This facility is being established to serve a
15 portion of Aurora that is a medically underserved
16 area. In our ongoing commitment to serve our
17 patients, Fresenius Medical Care operates clinics in
18 more medically underserved areas in Illinois than
19 any other ESRD provider. Along with the area's
20 medically underserved designation, East Aurora has a
21 population of 74 percent Hispanic with 18 percent
22 living below the poverty level.

23 These patients face economic and cultural
24 barriers to adequate health care services. Many are

1 indigent, uninsured and speak little or no English.
2 Fresenius' mission's policy is to accept all
3 patients regardless of ability to pay. All dialysis
4 patients in Illinois can obtain some type of
5 coverage whether Medicare, Medicaid or by grants
6 from the American Kidney Fund.

7 Our financial coordinators work diligent
8 with every patient to assist them in applying for
9 coverage that is right for them. Aurora has been a
10 part of my region for over 20 years. It is the
11 second largest city in Illinois and has grown
12 38 percent over the past decade. During that time
13 I've seen Aurora Clinic grow from a small 8 station
14 clinic to where it is today 24 stations and 122
15 patients.

16 This clinic is currently at 85 percent
17 utilization, despite the fact that we have added a
18 total of ten stations in the past two years. At
19 85 percent utilization this equates to 48 additional
20 patients.

21 This project meets the Board's criteria
22 except for station need due to excess station.
23 Sixteen excess stations in HS8 which is a large
24 geographic area. This excess of stations exists due

1 to rural clinics not operating six shifts and newly
2 approved clinics outside of 30 minutes travel time.
3 Some well over an hour away.

4 As evidenced by the utilization of
5 facilities within the 30 minutes travel time, there
6 is a pocket of need in the Aurora area. The only
7 other facility serving Aurora is Fox Valley which is
8 not a Fresenius clinic and is at 92 percent
9 utilization.

10 Aside from the needs seen by high area
11 utilization, this project has garnered enormous
12 support from the City of Aurora, Aurora alderman,
13 Aurora township, State Representative, Visiting
14 Nurse Association, Hesid House Homeless Shelter and
15 over 40 letters of support from patients and
16 community members. I'd like to hand this over to
17 Clare Ranalli for additional comments.

18 CHAIRMAN GALASSIE: Thank you.

19 MS. RANALLI: I will be extremely brief.
20 I just wanted to comment quickly on the opposition
21 to the project. The physician who spoke with the
22 Fox Valley Clinic in the area, it is within 30
23 minutes, but as Ms. Muldoon said, it's substantially
24 over the target utilization rate.

1 The other issue that was raised was
2 concerning Dr. Dodia's practice and his practice has
3 seen enormous growth over the years. In fact, at
4 the Aurora Clinic where he also admits, we have
5 added ten stations over the last few years and it
6 is, despite adding stations again and again and
7 coming to you for approval for same, it is well over
8 your utilization target rate which is why we see an
9 extreme need for the East Aurora Clinic.

10 Also, there were clinics that the doctor
11 mentioned, but they were outside of the 30 minute
12 radius and, as a state agency report or state board
13 report correctly points out, within a 30 minute
14 radius. All of the facilities are operating well
15 above the target utilization rate.

16 And, lastly, just to address an important
17 point that Justice Greiman raises, our market share
18 at HSA8 is 42 percent. Other dialysis providers
19 have 59 percent or 58, unless I am working on a 101
20 percent number, but in other words, we are not the
21 primary provider in this HSA.

22 CHAIRMAN GALASSIE: And how far is this
23 proposed facility from the Aurora facility?

24 MS. RANALLI: Approximately 2 miles.

1 CHAIRMAN GALASSIE: Questions by the Board
2 members?

3 MR. GREIMAN: I just want to comment that I
4 did check it after we had our conversation last time
5 and found that you have 49 percent of the stations,
6 of the units and 53 percent of the beds so you are
7 almost over the 50 percent mark.

8 MS. RANALLI: For the state, right.

9 MR. GREIMAN: So this may be the last time.

10 CHAIRMAN GALASSIE: Other questions by board
11 members? Member Sewell.

12 MR. SEWELL: So, essentially, your argument
13 is that within the planning area that the state uses
14 where, you know, who determines that there is no
15 need, you are saying that there is a targeted
16 smaller area within that where there is a great
17 need. Does that essentially hit it or am I putting
18 words in your mouth?

19 MS. MULDOON: We actually have a map. If
20 you looked at the map you could see on the HSA8 how
21 Aurora is. We highlight it towards green as far as
22 the patient population and it is very, very dark
23 green right in that Aurora area and then you span it
24 out over the HSA8 and the patients just start to go

1 down, the population goes down. It is just very
2 significant in that HSA8. So we do have a map if
3 you want to see that.

4 MS. WRIGHT: It is very little. Aurora is
5 down here.

6 MR. URSO: Was it in the application?

7 MS. WRIGHT: Not this map, but there was a
8 map of the area.

9 MS. RANALLI: If you look at the whole
10 HSA, it is very rural and there is only about two
11 areas that are heavily populated with patients, one
12 in Waukegan in Lake County and the other one is
13 Aurora in Kane County.

14 MS. MULDOON: Just one more thing is, when
15 we went to the ten station expansion, we did it
16 twice. I think we did six and then four and at that
17 time Dr. Dodia committed to admitting a total of 95
18 patients in both of those. We still have about 12
19 more months, he's already admitted 95 or 96. He is
20 one over what he said he committed to and we have
21 one over that so he is growing very rapidly in this
22 area.

23 MR. HAYES: I was just wondering from Mike,
24 this project was denied in August of 2011. So

1 basically what they have done is come back with a
2 new application?

3 MR. CONSTANTINO: That's correct. And
4 during that time we published a new inventory. We
5 changed the bed excess in that area and they also
6 did a travel study performed by a professional
7 engineer which we accepted over and above Map Quest,
8 so that's why you will see in excess of 16 stations
9 and then you see five of six facilities are now at
10 target occupancy where that wasn't the case before
11 within 30 minutes.

12 MR. HAYES: Okay. Thank you. I was also
13 just wondering and this is to the applicant.
14 Rush-Copley Medical Center, is that a hospital? And
15 they had a letter of opposition to your project?

16 MS. RANALLI: They did. They don't
17 operate a dialysis unit, but the physician and the
18 physician's partner who you heard from today are on
19 Rush-Copley's medical staff but they don't operate a
20 dialysis unit.

21 MR. HAYES: Thank you.

22 MR. HILGENBRINK: Mike, in that travel
23 study, did that only include personal auto or did it
24 include public transportation?

1 MR. CONSTANTINO: It was just an auto.

2 MR. HILGENBRINK: So just miles, not time?

3 MR. CONSTANTINO: Yeah. Three different
4 times during the day.

5 MR. HILGENBRINK: Can you comment on public
6 transportation? Did you include that in your
7 traffic study or analysis?

8 MS. WRIGHT: No. The study was conducted
9 by a professional traffic engineer and they just did
10 drive time studies.

11 MR. HILGENBRINK: Drive time or miles?

12 MS. WRIGHT: Drive.

13 CHAIRMAN GALASSIE: Do you find much of your
14 clientele utilize public transportation?

15 MS. MULDOON: Yes. They do utilize public
16 transportation.

17 CHAIRMAN GALASSIE: Something to consider in
18 the future.

19 DR. BURDEN: Mike, you said how many
20 estimated excess of the stations there were in
21 planning area 8?

22 MR. CONSTANTINO: Thirty-five.

23 DR. BURDEN: And it is reduced by half?

24 MR. CONSTANTINO: To, 16 now, yes.

1 DR. BURDEN: How is it if you re-drew map
2 like gerrymandering, do we call it?

3 MR. CONSTANTINO: Projected population.
4 Generally, most of it is on the projected
5 population.

6 CHAIRMAN GALASSIE: Any further questions?

7 (NO RESPONSE)

8 CHAIRMAN GALASSIE: Hearing none, may I have
9 a motion to approve Project 11-120 for the
10 establishment of a 12 station ESRD facility in East
11 Aurora, Illinois.

12 MR. HILGENBRINK: So moved.

13 MR. GREIMAN: Second.

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

16 MR. ROATE: Motion made by Mr. Hilgenbrink,
17 seconded by Justice Greiman. Dr. Burden?

18 DR. BURDEN: I will say no. Again, the
19 calculations are based on math and, I think, when we
20 get to a point where we need Fresenius, we will be
21 here.

22 MR. ROATE: Mr. Eaker?

23 MR. EAKER: Yes.

24 MR. ROATE: Justice Greiman?

1 MR. GREIMAN: Yes. My last vote for you.

2 MR. ROATE: Mr. Hayes?

3 MR. HAYES: No, because of the excess 16
4 stations in the planning area.

5 MR. ROATE: Mr. Hilgenbrink?

6 MR. HILGENBRINK: Yes.

7 MR. ROATE: Ms. Olson?

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

9 MR. ROATE: Mr. Sewell?

10 MR. SEWELL: No, excess capacity.

11 MR. ROATE: Chairman Galassie?

12 CHAIRMAN GALASSIE: No, same reasons.

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

15 CHAIRMAN GALASSIE: Good luck. Motion does
16 not pass.

17 MR. URSO: So you will be receiving an ITD.

18 CHAIRMAN GALASSIE: Moving on to item H13,
19 Project 11-103 Lawndale Dialysis. One public
20 comment.

21 MR. MORADO: Mr. David Frankel.

22 CHAIRMAN GALASSIE: Thank you. Good
23 afternoon.

24 MR. FRANKEL: Good afternoon,

1 Mr. Chairman, and members of the board. My name is
2 David Frankel and I serve as Vice-president of
3 Planning and Marketing Communications for Sinai
4 Health System, the not-for-profit parent
5 organization of Mount Sinai Hospital and Schwab
6 Rehabilitational Hospital. Sinai is located on the
7 west side of Chicago at the intersection of Ogden
8 and California Avenues in the center of the
9 culturally rich but economically challenged north
10 and south Lawndale communities.

11 I am here today to express Sinai's strong
12 opposition to review this application to establish a
13 new 16 station dialysis center in South Lawndale
14 which would be located only 2.2 miles or seven
15 minutes travel time from Mount Sinai Hospital which
16 is currently licensed for 16 dialysis stations.

17 Section 5.4 of the Illinois Health
18 Facilities Planning Act requires applications for
19 subsequent projects to include a safety net impact
20 statement which is to describe the proposed
21 project's material impact and essential station and
22 services in the community and the project's impact
23 on the ability of another provider or healthcare
24 system to cross subsidize safety net services.

1 Mount Sinai Hospital is precisely the type
2 of stage end provider whose interests in the
3 community residents are to be protected by the
4 statutory requirements. Given that 53 percent of
5 the existing dialysis facilities within 30 minutes
6 of the applicant's proposed new facility are
7 operating at a below the state utilization standard,
8 Sinai's leadership is concerned that the proposed
9 new for profit dialysis facility will negatively
10 impact the 24 underutilized centers and collectively
11 pull in patients covered by Medicare and private
12 health insurance that we and nearby providers might
13 otherwise serve. It is the revenue generated by
14 these favorably insured patients that helps sustain
15 Sinai's ability to serve our community as a major
16 provider of Medicaid and charity care services.

17 Consequently, we believe that this
18 proposed project would have a significant negative
19 impact on our organization's ability to cross
20 subsidize essential safety net services such as
21 level one trauma, neurosurgery and dialysis care for
22 uninsured patients. We contend that to do this CON
23 application for permit, 11-103 does not offer
24 complete information or accurate conclusions

1 regarding safety net impact.

2 On behalf of Mount Sinai Hospital, I
3 respectfully suggest that absence and failure to
4 meet the board's requirements should lead you each
5 to vote to deny approval for the CON application to
6 build a new for profit dialysis facility in South
7 Lawndale. Thank you.

8 CHAIRMAN GALASSIE: Thank you.
9 Representatives of the Lawndale Dialysis. Good
10 afternoon, folks. Please introduce yourselves and
11 spell your name for our reporter, please.

12 MS. DAVIS: Penny Davis, I'm the Division
13 Vice-president for DaVita.

14 DR. ANEZIOKORO. My name is Ogbonnaya
15 Aneziokoro. I will spell that.
16 A-N-E-Z-I-O-K-O-R-O. I'm a nephrologist in Chicago.

17 MR. VAN LEER: My name is Joseph VanLeer.
18 I'm counselor for the applicant.

19 MS. FRIEDMAN: I'm Kara Friedman.

20 CHAIRMAN GALASSIE: Do a collective swearing
21 in.

22 (WITNESSES ARE SWORN)

23 CHAIRMAN GALASSIE: Thank you. Staff
24 report, please.

1 MR. CONSTANTINO: The applicants are
2 proposing establishment of a 16 station ESRD
3 facility in approximately 6800 gross square foot of
4 space at a cost of approximately \$3.1 million. No
5 public hearing was requested. I would like to point
6 out that I failed to include letters of support in
7 opposition in the State Agency Report. You heard an
8 opposition letter from Mount Sinai. In response to
9 that, DaVita stated the proposed facility will not
10 impact Mount Sinai. The planned 16 station ESRD
11 facility will improve access to life-sustaining
12 dialysis treatment with the highest level of care
13 for a largely low income minority urban community.
14 Finally, there is a need for 112 stations in the
15 ESRD planning area. Thank you, Mr. Chairman.

16 CHAIRMAN GALASSIE: Thank you, sir. Who
17 would you like to address the board.

18 MS. DAVIS: We are seeking, as you know,
19 to establish Lawndale Dialysis, which would be a 16
20 station facility serving the chronically ill patient
21 population in the Lawndale area of Chicago. For
22 those of you who don't know, that is on the west
23 side and it is a very impoverished area.

24 Chicago has a significant calculated need

1 for dialysis stations, 100 station need based on
2 projected needs for 2013 when this facility would
3 open. It is one of the highest need rates in the
4 state for end stage renal disease services.

5 Utilization exists of 15 providers to
6 accommodate the growing demand for dialysis is not
7 feasible. The average utilization of existing
8 facilities nearby is 78 percent. Our closest area
9 facility, Little Village, is operating at 98 percent
10 utilization. We have operated at that level for
11 some time and haven't been able to serve additional
12 patients due to our inability to expand at that
13 site.

14 As you know, we are committed and we
15 brought several projects to this Board to serve the
16 inner city of Chicago and it is our continued
17 commitment. We understand Mount Sinai's position.
18 Their facility at California and 15th is operating
19 only 15 of its 16 stations and we met with them and
20 they can't open a 16th station because of space
21 constraints and they are currently operating at
22 88 percent utilization. That would only allow for,
23 approximately, a dozen patients on off shifts to be
24 completely full.

1 That facility is also utilized almost
2 exclusively by their own employed nephrologists who
3 have not committed patients to our facility.
4 Utilization has increased by 350 patients since
5 January 1, 2011. That is an incredible number of
6 ESRD patient growth. The facility will serve
7 primarily low income and minority population which
8 is reflective of the community and facilities served
9 and reflective of the fact that, compared to non
10 Hispanic, Hispanics are one and a half more times
11 likely to develop kidney failure.

12 I would like to request your approval and
13 I will turn over the microphone to Dr. OGB, as we
14 call him, who would be our medical director and
15 partner in this new facility.

16 DR. ANEZIOKORO: Good afternoon, Chairman
17 and members of the Board. Thank you for giving us
18 this opportunity to address the board tonight. I
19 will just state that I am Dr. Aneziokoro and a
20 physician and nephrologist in the Lawndale
21 community.

22 Essentially, I've been serving this
23 community for the past six years. I trained at the
24 University of Chicago and after mulling over it, I

1 eventually decided on go into private practice just
2 because I needed patient care. Essentially, ever
3 since then after serving this community, which is
4 predominantly made of Hispanics, 98 percent of this
5 community is Hispanic and African American
6 population and one thing about it is not just run of
7 the mill Hispanics and African Americans. It is an
8 extremely low income group.

9 As we all know, some of us don't know, is
10 that diabetes and hypertension are the commonest
11 causes of ESRD in this community and essentially
12 diabetes is almost an epidemic now. We all know
13 that, and especially in this community the African
14 Americans and Hispanics, the lower socio-economic
15 class.

16 The bottom line is that it is almost a
17 social disease right now in these group of patients
18 and this is the patients that we actually serve.
19 Lawndale a classic example of this group of
20 patients.

21 So I think our goal as health care
22 providers and human beings, in general, will make a
23 difference in the lives of the people and this is
24 why we are here today. This is to protect and serve

1 this community that would make a difference in the
2 lives of these people. There is a unit that she
3 mentioned here and it served this community and last
4 year 138 patients were dialyzed at Little Village,
5 so 5 percent of them were Hispanics, 23 percent
6 African Americans, 98 percent. And of these 138
7 patients, only eight of them had private insurance .
8 Every other patient was either Medicare, Medicaid or
9 not insured at all. So this is one of the reasons
10 we are here today.

11 Besides that, I, in the past six years
12 I've grown my CK population out of a clinic located
13 in this area and between myself and Dr. McGuyen, he
14 is a nephrologist, we have well over 168 patients.
15 The majority of them, about 140 of them, are stage
16 four and stage five and from history we know that
17 stage four and stage five in the next two years they
18 will all end up in dialysis, probably a few months
19 to a few years so how do we serve that group. Just
20 from one clinic in this neighborhood? This is
21 essentially why we are here today.

22 I think we have to plan for right now and
23 the future. We can't look at what we have right now
24 without thinking about what is going on in the

1 future. Besides that, I go to five dialysis units
2 right now. Two on the north side, one on the south
3 side and one in Skokie and one in Little Village and
4 I serve this neighborhood. Literally as of last
5 week we have a capacity of 96 patients. We have 91
6 patients at 95 percent capacity. Five more patients
7 and the unit is closed.

8 Now, this project was born out of these
9 things that I talk about, the fact that we have
10 difficulty placing patients. We talk about having
11 facilities, but the bottom line is that you have an
12 Hispanic 45 year old who is the sole bread winner of
13 his family. He has four kids and he works from 9 to
14 5 and now besides -- oh, unfortunately for him, he
15 ends up on dialysis. Now the only shift he can get
16 because he has to work from 9 to 5 is a 5:00 a.m.
17 shift and you go around the neighborhood and you
18 cannot place him in a 5:00 a.m. shift. This is the
19 sole bread winner of this family. He would have to
20 quit his job or miss dialysis.

21 Now, interestingly and unfortunately,
22 patients right now actually are not as trusting of
23 the medical profession as they were in the past and
24 you would be surprised at the number of patients who

1 had patients on dialysis will tell you, oh, dialysis
2 is a death sentence and it actually is not. What
3 happens, I will give you a classic interaction
4 between a patient and myself.

5 A 70-year old Hispanic male, hypertension,
6 diabetes and has seven kids. He is married, his
7 wife was a home maker. I've been seeing him for
8 five years and he tells me, you know, if I ever get
9 on dialysis or if I ever have to get on dialysis, he
10 is CK stage four and he is probably 10 to 15 percent
11 of renal function. I said to him, listen, it is
12 time for you to get on dialysis. He tells me, Doc,
13 absolutely not. I would rather die then get on
14 dialysis. We finally convince him to get on
15 dialysis. This will be good for you. We talk sense
16 to him and make you breathe better. We started him
17 on dialysis. He starts feeling better and he thinks
18 you are a miracle worker. He thanks you and
19 eventually you tell him, Mr. Santiago, I'll make
20 sure that when going for dialysis you have somewhere
21 close where you can go to dialysis.

22 The social workers look for dialysis
23 centers and there is a dialysis center away from
24 this place and he can't get in there. They put him

1 in a dialysis center 5 to 10 miles away from his
2 place. That is not a far distance if you're driving
3 or if you can get around. But it is a distance if
4 you have to take public transportation or for
5 patients who are disabled. By the way, Mr. Santiago
6 is a bilateral amputee. Those are the kind of
7 patients we see. Then he finally jumps over the
8 hoop and he says I will figure out a way to get
9 there. He tells me, Doc, when am I going to see you
10 in the clinic again? I said, well, the bottom line
11 is there is a nephrologist who I know who is going
12 to be taking care of you and he tells me, listen,
13 Doc, you've taken care of me for five years, why
14 can't you take care of me. I tell him, well, I want
15 you to have dialysis and this family who once
16 thought of me as a shining angel now believes I've
17 abandoned them. I can physically go to nine or ten
18 dialysis units, it's possible, but how physical is
19 that and that's what happens if you have to shift
20 your patients throughout place to place. These are
21 the kind of patients we get. I could go on and go
22 on and go on and that is essentially what is going
23 on?

24 CHAIRMAN GALASSIE: Thank you, Doctor. I

1 think we understand the challenge that you are
2 facing.

3 MS. DAVIS: We will be happy to answer any
4 questions.

5 CHAIRMAN GALASSIE: Great. Let me open it
6 up to questions from the Board.

7 MR. SEWELL: It seems like from your
8 testimony that you've got a combination of very high
9 prevalence of end stage renal disease, but then we
10 have these underutilized dialysis stations which is
11 creating lack of compliance with that criteria so,
12 obviously, people are either A, who need dialysis
13 and are not getting it or they are going outside the
14 planning area. Now, that area is not that far from
15 a lot of medical facilities outside of the planning
16 area. So don't you think that is what's happening
17 is that people are going outside the planning area?
18 I mean, there is a little bit more travel time but,
19 because you've got the high prevalence of end stage
20 renal disease.

21 MS. FRIEDMAN: Well, there are a couple of
22 things. First, you did hear that there were 350 new
23 patients that are initiated. So clearly, those are
24 initiating in center dialysis.

1 Also, you know, we are talking about the
2 neighborhood and just beyond and the utilization and
3 that utilization is at 78 percent. I think that
4 sometimes the staff is taking facilities that are
5 not yet open and saying there is capacity at those
6 centers, but different physicians have committed
7 different CKD patients to those locations so
8 78 percent for the patients that live within
9 Lawndale, 88 percent at Mount Sinai and 95 percent
10 at Little Village. I mean, I think those are more
11 of a reflection of what this community has access
12 to.

13 MR. CONSTANTINO: We are required for
14 planning purposes to take all approved facilities in
15 our need calculation and that's what we've done on
16 this application as well as others.

17 MS. FRIEDMAN: Right. I don't want to fault
18 him, it's just that they are not accessible to
19 patients yet when they are not open.

20 MS. DAVIS: I also -- when we were looking
21 for where we would build our next location, we went
22 to the National Kidney Foundation of Illinois and
23 asked where the highest ESRD population is and she
24 came back to me and said, Penny, the highest

1 population of diabetes is in the Lawndale community
2 and diabetes is the number one precursor to end
3 stage renal disease.

4 So as that grows, if you look at 350
5 patients coming in over at a year and you have Mount
6 Sinai that has maybe capacity for 12, our Little
7 Village facility maybe capacity for 5, it will take
8 us well over a year to build this facility. So by
9 that time you've got another 350 patients who are
10 coming into end stage renal disease and will need
11 treatment.

12 Our fear is that without close access,
13 these patients who have limited ability to get
14 around for transportation, are going to just not get
15 dialysis. They will go without or they will stay in
16 the County Hospital. The County Hospital is running
17 at 160 percent occupancy in their dialysis unit
18 because these are patients that are unable to be
19 moved out into the community because patients aren't
20 insured.

21 As you all know, we take any patient
22 regardless of their ability to pay. So we are
23 looking at serving the same population that County
24 serves, that Sinai serves in terms of being a safety

1 net provider within this community.

2 CHAIRMAN GALASSIE: Other questions from the
3 the board members? Mr. Hilgenbrink.

4 MR. HILGENBRINK: I don't think Mike
5 finished the explanation. I would like a
6 clarification if you count units in the service
7 area.

8 MR. CONSTANTINO: We are required by your
9 rules to look at all facilities that have been
10 approved by this board when we look at facilities
11 within 30 minutes. We take that into consideration
12 when looking at the utilization of those facilities.

13 The new facilities aren't open yet, but
14 their utilization is zero so we take that into
15 consideration as not meaning our target occupancy.
16 We have done that and this is the way we conducted
17 these reviews for the past 30 years and that hasn't
18 changed. There is no new rules.

19 I would also like to point out and I
20 should have read this earlier. Mount Sinai, when
21 they provided their letter of opposition, which I
22 didn't include, mistakenly did not include in the
23 report, they stated their para mix for the ESRD
24 facility is 10 percent uncompensated care and DaVita

1 does not have any. 30 percent Medicaid and the
2 remainder is Medicare.

3 So there is something unusual going on in
4 this area and I don't know what it is, but Mount
5 Sinai is concerned that DaVita will take patients
6 which are providing them, which they would be able
7 to get a higher rate for than what they currently
8 are now. That is what Mount Sinai's concern is.

9 MS. DAVIS: If I could speak to the
10 uncompensated care. We take patients that are
11 uncompensated all the time.

12 MR. CONSTANTINO: That isn't what you are
13 reporting to us.

14 MS. DAVIS: Well, what we do is help them
15 get on to Medicaid and Medicare because it is
16 mandated by the state and by the Federal government
17 that end stage renal disease patients are covered
18 under one of those two programs. So even
19 undocumented immigrants are covered under a state
20 mandated program for dialysis and we work with those
21 patients and our social workers to help them get
22 coverage because it also provides them get coverage
23 for transportation, medication and everything else
24 that they might need.

1 CHAIRMAN GALASSIE: I will bring it back to
2 the Board. Any further questions?

3 (NO RESPONSE)

4 CHAIRMAN GALASSIE: Seeing none, may I have
5 a motion to approve Project 11-103 for the
6 establishment of a 16 station ESRD facility Chicago,
7 Illinois.

8 DR. BURDEN: So moved.

9 MR. HILGENBRINK: Second.

10 CHAIRMAN GALASSIE: Move and seconded. Roll
11 call, please.

12 MR. ROATE: Motion made by Dr. Burden,
13 seconded by Mr. Hilgenbrink. Dr. Burden?

14 DR. BURDEN: I'm still conflicted but I feel
15 that Mount Sinai brings an awful lot to the
16 community. The Russian Jewish community has kept
17 that institution alive in an area where it is vital
18 and there is struggling going on at that
19 institution. However, I'm impressed by the
20 University of Chicago trained gentleman here whose
21 got nice smile and nice personality and I think he
22 is a hardworking guy. He is serving plenty of
23 patients in the community and I duly noted that
24 there are 112 ESRD patients that are needed. I

1 can't understand the data that I'm hearing, but I
2 would vote yes for this even though I'm not in love
3 with DaVita as an organization, you know that, I am
4 impressed that this guy will bring something to the
5 table.

6 MR. ROATE: Mr. Eaker?

7 MR. EAKER: I will vote no because of the
8 under utilization in the planning area.

9 MR. ROATE: Justice Greiman?

10 MR. GREIMAN: I vote no.

11 MR. ROATE: Mr. Hayes?

12 MR. HAYES: Yes.

13 MR. ROATE: Mr. Hilgenbrink?

14 MR. HILGENBRINK: Yes.

15 MR. ROATE: Ms. Olson?

16 MS. OLSON: I voted no based on negative
17 impact of other area providers.

18 MR. ROATE: Mr. Sewell?

19 MR. SEWELL: I vote no because on table four
20 there are still several that haven't opened yet.

21 MR. ROATE: Chairman Galassie?

22 CHAIRMAN GALASSIE: Yes.

23 MR. ROATE: That's four votes in the
24 negative and four votes in the positive.

1 CHAIRMAN GALASSIE: Motion fails.

2 MR. URSO: You will be receiving an intent
3 to deny and another opportunity to come before the
4 board and supply additional information.

5 CHAIRMAN GALASSIE: Thank you very much.
6 Moving on to Project 11-109 Logan Square Dialysis.
7 Any public comment hearing? No public comment. Can
8 we have a staff report.

9 MR. CONSTANTINO: The applicants are
10 proposing to discontinue a 20 station ESRD facility
11 and establish a 28-station facility. The cost of
12 the project is approximately \$4.8 million. There
13 was no public hearing requested and finally
14 67 percent of the facilities in this service area
15 are below the target occupancy. Thank you,
16 Mr. Chairman.

17 CHAIRMAN GALASSIE: 67?

18 MR. CONSTANTINO: Sixty-seven, yes.

19 CHAIRMAN GALASSIE: Thank you. You would
20 like to speak to the board, Penny?

21 MS. DAVIS: Yes, thank you. This is a
22 relocation project in the City of Chicago. We are
23 moving Logan Square Dialysis less than a half mile
24 away into a new building. In doing so when the area

1 has experienced a 6 percent utilization increase in
2 just the last year.

3 The Logan Square Building is old and has
4 been operating for more than 25 years at that
5 location. Ongoing repairs at the facility have been
6 maintained over time, but there are structural
7 issues that we cannot overcome with repairs, we have
8 tried. These problems primarily relate to the
9 biomed sports space and the physical layout
10 generally.

11 Part of the issue also is related to the
12 foundation of the building and something about the
13 compacting of the soil underneath it, so we actually
14 have flooring that is sinking and has over the
15 years. It's leased space, but we fully control
16 these issues. After 26 years here it is time to
17 find a new site and develop a better operation.

18 We've discussed with you in the past the
19 difficulty in Chicago to find adequate site for
20 services and to do construction projects in the
21 city. We were very close to firming up a site for
22 this location last May in anticipating being
23 reviewed in the summer and fall. That site fell
24 through. As such, we went through the local

1 alderman, Alderman Cologne, who was anxious to move
2 forward with us in the new space. He helped us
3 locate a location. We had several community
4 meetings with the neighborhood and have had
5 resounding support from the community with DaVita as
6 a neighbor and for our relocation up the street, as
7 if we would be going into what had been an abandoned
8 lot.

9 Parking issues are a challenge. It is
10 right on Milwaukee Avenue currently and so there are
11 no dedicated staff or patient parking. Patient pick
12 up, drop off is right on Milwaukee Avenue right near
13 the bus stop so it gets dangerous and challenging.
14 Without a drop off area on Milwaukee at the current
15 facility, family members and other transportation
16 vehicles are required to double park on Milwaukee
17 prior to dropping off patients and then parking
18 remotely. Staff have the same problems and have to
19 often times park blocks away on meters parking down
20 the street.

21 Patients will be transitioned to the site
22 by the end of 2013 when the projected station needs
23 also show significant increase. We believe the need
24 figure is correct. In the last year ending

1 12/31/2011 there was a 6 percent increase of
2 dialysis patients in the city. This trend of
3 experience of need figure is supported by what is
4 actually happening in the area. While just the
5 6 percent trend alone would bring utilization to
6 80 percent in the first year of operation with about
7 135 patients, Dr. O provided a larger list of 80
8 patients who will require dialysis at the time the
9 facility opens.

10 Again, we've been operating above the
11 state's 80 percent utilization standard for many
12 years, typically 90 to 98 percent utilization. We
13 serve primarily in the Hispanic and the African
14 American community and the majority of disabled are
15 disabled by health conditions which create
16 additional economic challenges. We believe that
17 these patients deserve to be served in a facility
18 that is designed to meet their needs and which does
19 not have the problems that our current building
20 does. I would like request approval of our project
21 and answer any questions you might have.

22 CHAIRMAN GALASSIE: Thank you very much.
23 Any questions on the part of board members?

24 MS. OLSON: I have a comment. I have some

1 concern that the new game that we're playing here is
2 that you have to get out of where you're at because
3 the building is dilapidated. We keep hearing this
4 over and over again and so then you move to a new
5 place and add stations. I guess what I would say is
6 I could support this application if you were moving
7 from a 20 stage building to a new 20 stage building
8 but I think that building the eight stations is a
9 way to scam the game to try to get around the fact
10 that we have underutilized facilities in the area.

11 MS. DAVIS: Well, in answer to that,
12 because we are typically writing 90 to 98 percent
13 with that current number of stations, that's why we
14 are asking for the additional stations. We
15 currently cannot offer a patient the opportunity to
16 have a time frame that they want.

17 MS. OLSON: At that facility?

18 MS. DAVIS: At that facility. So the
19 doctors that provide service at that facility, you
20 know, they're the ones who have the additional CKB
21 patients that will need services over the next
22 couple of years and I think it is Dr. RGB who spoke
23 to it so well.

24 You go to one doctor and he goes to this

1 facility and that facility. He does not want and
2 can't because of time constraints go to a third,
3 fourth or fifth facility and, I think, what is
4 really important to understand is that I don't want
5 to go to another doctor just because the facility he
6 goes to doesn't have room for me. It is a trust
7 issue for me.

8 CHAIRMAN GALASSIE: Other questions? .

9 (NO RESPONSE)

10 CHAIRMAN GALASSIE: Hearing none, may I have
11 a motion to approve Project 11-109 --

12 MR. GREIMAN: So moved.

13 CHAIRMAN GALASSIE: -- for discontinuation
14 of 20 station ESRD facility and establishment of 28
15 station ESRD facility in Chicago, Illinois.

16 We have a motion

17 DR. BURDEN: Second.

18 MR. ROATE: Motion made by Justice Greiman,
19 seconded by Dr. Burden.

20 CHAIRMAN GALASSIE: Roll call, please.

21 MR. ROATE: Dr. Burden?

22 DR. BURDEN: This is always a complicated
23 issue. I agree with what I heard from my fellow
24 member on the board of the quote unquote scamming

1 the system, but I think that I will vote for this
2 because I sense that this is another area of
3 significant need. I vote yes.

4 MR. ROATE: Mr. Eaker?

5 MR. EAKER: I vote no.

6 MR. ROATE: Justice Greiman?

7 MR. GREIMAN: Aye.

8 MR. ROATE: Mr. Hayes?

9 MR. HAYES: Yes.

10 MR. ROATE: Mr. Hilgenbrink?

11 MR. HILGENBRINK: Yes.

12 MR. ROATE: Ms. Olson?

13 MS. OLSON: No, for the reason stated.

14 MR. ROATE: Mr. Sewell?

15 MR. SEWELL: No.

16 MR. ROATE: Chairman Galassie?

17 CHAIRMAN GALASSIE: Yes.

18 MR. ROATE: That is five votes in the
19 affirmative, three votes in the negative.

20 CHAIRMAN GALASSIE: Motion passes.

21 Congratulations. And moving on to H15, Project
22 11-114 Lake County Dialysis. We will move right on
23 to staff report.

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

1 The applicants are proposing to discontinue a 16
2 station facility and establish a 20 station
3 facility. The cost of the project is approximately
4 two and a half million dollars. There is no public
5 hearing and no letters of support in opposition were
6 received. Nine of the 11 facilities within 30
7 minutes are underutilized and the existing facility
8 has not been at target occupancy for the past 12
9 months. There is an excess of 16 stations in this.

10 CHAIRMAN GALASSIE: Thank you. Comments to
11 the board?

12 MS. DAVIS: All right. Again, this is a
13 relocation project in Lake County. We have operated
14 at this site for over 20 years and during that time
15 the Multi-dealer Auto Plaza was built up around our
16 facility. Being at the site is truly peculiar as
17 the area around the facility has become the largest
18 auto dealership in Lake County.

19 The development of this stretch of
20 Milwaukee Avenue as a car dealership has impaired
21 the function of this building for our patients. We
22 are essentially pinned in by car dealerships. Given
23 that we don't have long term lease obligations, we
24 want to operate at a location that is better suited

1 for the delivery of medical services. There is no
2 dedicated parking for patients, visitors or staff
3 and patients and dealership traffic make it very
4 difficult for patients to park. I don't know if
5 you've ever seen cars driving through a car
6 dealership, but they don't drive slow especially the
7 porters.

8 For non-ambulatory patients, vehicles must
9 drive through the dealership to be dropped off and
10 picked up in the alley at the rear of the building.
11 Besides the site issues, the existing facility is
12 located in a building that is old, poorly configured
13 and in need of repair. There are multiple grade
14 changes in the flooring which make it difficult for
15 us to move wheelchairs through the facility and
16 storage is located in an alley closet and, in
17 addition to that, we have constant utility issues.
18 When the electricity goes out, we have to stop
19 dialysis and send patients to other facilities up to
20 a half hour away.

21 In the meantime, continued utilization of
22 this facility in the planning area has continued to
23 increase. The census in 2011 at the facility
24 increased from 68 at the beginning to 79 at the end

1 of the year as reported in our most recent survey to
2 the board that is clearly a 16 percent increase.

3 The population within a radius of 5 miles
4 of this site is over 120,000 people and we have been
5 the only dialysis facility in this radius during the
6 years we have operated. The planning area in which
7 Lake County is located includes three large
8 counties. If you focus on just Lake County, where
9 the patients served by this facility reside, the
10 average utilization of the facility is 78 percent as
11 of 12/31/11. Advocate Condell, which is the nearest
12 hospital and is across the street, has presently
13 gone on record regarding the need for hemodialysis
14 services in the area in a letter to the board dated
15 December 5, 2011.

16 With even modest growth, this facility
17 will not be able to accommodate the expected case
18 load within two years of completion of this project
19 at its current location. I would like to request
20 approval of and offer to answer any questions you
21 may have.

22 CHAIRMAN GALASSIE: Thank you. Entertain
23 questions from the board?

24 (NO RESPONSE)

1 CHAIRMAN GALASSIE: Hearing none, I will
2 make a motion to approve Project 11-114 for the
3 discontinuation of a 16 station ESRD facility and
4 the establishment of the 20 station ESRD facility in
5 Vernon Hills, Illinois.

6 MR. SEWELL: So moved.

7 DR. BURDEN: Seconded.

8 MR. ROATE: Motion by Member Sewell,
9 seconded by Dr. Burden.

10 CHAIRMAN GALASSIE: Roll call, please.

11 MR. ROATE: Dr. Burden?

12 DR. BURDEN: Again, we very have a situation
13 where there is a calculated excess of beds, 16, and
14 there is 11 existing or approved facilities within
15 30 minutes that have an average underutilization
16 rate of 62 percent below the state requirements and
17 the system, of course, has been requesting to
18 increase the number of stations. I have problems
19 with the increasing number so I will say no.

20 MR. ROATE: Mr. Eaker?

21 MR. EAKER: No, same reasons.

22 MR. ROATE: Justice Greiman?

23 MR. GREIMAN: Yes.

24 MR. ROATE: Mr. Hayes?

1 MR. HAYES: Yes.

2 MR. ROATE: Mr. Hilgenbrink?

3 MR. HILGENBRINK: Yes.

4 MR. ROATE: Ms. Olson?

5 MS. OLSON: No, for the same reason stated.

6 MR. ROATE: Mr. Sewell?

7 MR. SEWELL: No, excess capacity.

8 MR. ROATE: Chairman Galassie?

9 CHAIRMAN GALASSIE: Yes.

10 MR. ROATE: That's four votes in the

11 positive and four votes in the negative.

12 CHAIRMAN GALASSIE: Motion does not pass.

13 MR. URSO: You will receive an ITD and if

14 you wish to present any additional information.

15 CHAIRMAN GALASSIE: Thank you. Item H16

16 McAllister Nursing and Re-hab is deferred. Moving

17 on to item I on the agenda, Application Subsequent

18 to Intent to Deny, Item 11-01 Project 11-100 Oak

19 Surgical Institute. Any public comment? Hearing no

20 public comment, members representing Oak welcome to

21 the table. Introduce yourself to the reporter and

22 spell your last name, please.

23 MS. MOORE: My name is Joy Moore,

24 M-O-O-R-E, the Executive Director at Oak Surgical

1 Institute.

2 MR. MICHALOW: Alexander Michalow, I'm the
3 Medical Director at Oak Surgical Institute.

4 MS. FROGGE: Margaret Frogge, F-R-O-G-G-E,
5 Riverside Medical Center, Oak Surgical Institute
6 Board member.

7 MR. ROGAL: Ira Rogal, R-O-G-A-L.

8 CHAIRMAN GALASSIE: Thank you very much.
9 Can we do a collective swearing in, please.

10 (WITNESSES ARE SWORN)

11 CHAIRMAN GALASSIE: Staff report, Mike.

12 MR. CONSTANTINO: Applicants are proposing
13 to add podiatry as a surgical specialty to a limited
14 specialty ASTC. If approved, the applicants will
15 become a multi-specialty ambulatory surgical
16 treatment center. The applicants were given an
17 intent to deny at the January 2012 meeting. We did
18 receive support letters in support of this project
19 from Riverside Medical Center. Thank you,
20 Mr. Chairman.

21 CHAIRMAN GALASSIE: Thank you. Who would
22 like to speak to the board?

23 MS. MOORE: I will. Again, my name is Joy
24 Moore. Good afternoon. Thank you for the

1 opportunity to come back before you again. As you
2 will remember, Oak Surgical Institute is a limited
3 ambulatory surgery center which is requesting to add
4 an additional specialty and that specialty is
5 podiatry.

6 As stated in our supplemental information
7 letter, our current utilization is at 68.9 percent.
8 It's anticipated with the addition of the podiatry
9 services, utilization will be up to 77 percent. The
10 project does not involve any increase in any number
11 of operating rooms or any equipment purchased or any
12 cost of any kind.

13 We have submitted two letters of support
14 from the facilities in the intended geographic
15 services area. One is from Riverside Ambulatory
16 Surgery Center, and according to the state agency
17 report, it is at capacity. The other letter is from
18 Riverside Medical Center. In addition to the
19 letter, Ms. Hansen-Frogge has joined us here today
20 to provide support.

21 The only other facility in the geographic
22 service area is an endoscopy center and that is a
23 limited specialty center and there is St. Mary's
24 Hospital and neither has provided any impact

1 letters.

2 Also, there was no request for any public
3 hearing on this project.

4 We respectfully ask for your approval of
5 the project to add podiatry services. As we did at
6 the previous hearing, we agree not to add any
7 additional procedures to our services without coming
8 back to the board for your approval and I believe
9 that is it.

10 MR. MICHALOW: I'm the medical director at
11 Oak Surgical Institute and thank you again for
12 hearing us. We just hired a podiatrist last year in
13 October and he's not been able to perform any
14 surgical procedures at the surgical center. As Ms.
15 Moore has stated, we could increase utilization from
16 68 to 77 percent potentially. It would be more
17 efficient use of the podiatrist's time. We have a
18 high efficiency rating there and I think it will
19 also enhance our patients' experience which has been
20 very good there and I'm just asking for approval to
21 keep it short and sweet. Thank you.

22 CHAIRMAN GALASSIE: Questions from board
23 members?

24 (NO RESPONSE)

1 CHAIRMAN GALASSIE: Hearing none, may I have
2 a motion to approve Project 11-100 for the addition
3 of a surgical specialty to a limited specialty ASTC
4 in Bradley, Illinois.

5 DR. BURDEN: So moved.

6 MR. HILGENBRINK: Second.

7 CHAIRMAN GALASSIE: Moved and seconded.

8 MR. ROATE: Motion made by Dr. Burden and
9 seconded by Mr. Hilgenbrink.

10 CHAIRMAN GALASSIE: Roll call.

11 MR. ROATE: Dr. Burden?

12 DR. BURDEN: As the day moves on the
13 questions slow down from my end. I say yes.

14 MR. ROATE: Mr. Eaker?

15 MR. EAKER: Yes.

16 MR. ROATE: Justice Greiman?

17 MR. GREIMAN: Yes.

18 MR. ROATE: Mr. Hayes?

19 MR. HAYES: Yes.

20 MR. ROATE: Mr. Hilgenbrink?

21 MR. HILGENBRINK: Yes.

22 MR. ROATE: Ms. Olson?

23 MS. OLSON: Yes.

24 MR. ROATE: Mr. Sewell?

1 MR. SEWELL: No.

2 MR. ROATE: Chairman Galassie?

3 CHAIRMAN GALASSIE: Yes.

4 MR. ROATE: That is seven votes in the
5 affirmative, one in the negative.

6 CHAIRMAN GALASSIE: Motion passes.

7 Congratulations. Good luck to you. Moving on to
8 Project 11-095 Palos Hills Surgery Center. We have
9 one public comment. If you will come to the table
10 and introduce yourself and spell your last name,
11 please. Sylvia Wiley. Good afternoon.

12 MS. WILEY: Thank you so much for allowing
13 me the opportunity to speak with you this afternoon.
14 I am a registered nurse in the State of Illinois and
15 I am also a case manager. I have worked very
16 closely with the Mid-American Hand to Shoulder
17 Clinic. As an ER nurse, I have been very fortunate
18 and blessed to have physicians willing to take
19 members from Roseland Community Hospital in the
20 middle of the night with no medical insurance for
21 traumatic injuries to hands or upper extremities and
22 I appreciate that from the physicians. They have
23 always answered all of my phone calls. They have
24 been very cooperative with the patients and they

1 have never denied anyone care.

2 Providing a surgical center in Palos Hills
3 would not only be an asset, but it would be a
4 benefit to members of the community that cannot get
5 into the major hospitals in the area because of over
6 impact in the surgical rooms.

7 The physicians are trying to eliminate the
8 extended waits in the ERs. As an ER nurse, there
9 are times the patients cannot be seen for six to
10 eight, sometimes 12 hours. At that time they are
11 directed back to their primary care physician. The
12 primary care physicians, in an attempt to cost
13 contain, will try to handle these problems
14 themselves when we can actually have a cost savings
15 by having the patients directly seen by the hand or
16 upper extremity specialist at that time.

17 Also, it would be a benefit that these
18 patients are seen by these specialists so that the
19 proper care can start right away. As you know, cost
20 is essential and insurances are constantly informing
21 patients of where they can and cannot go for their
22 care and we have physicians here who are willing to
23 help everyone in the community, not just the Palos
24 Hills community, the Roseland community at all

1 times, and it is my request that you would allow
2 this facility to have a surgical center where
3 surgical procedures can be performed at all times of
4 the day or evening as needed. Thank you so much.

5 CHAIRMAN GALASSIE: Thank you for your
6 comments. If you folks would introduce yourself to
7 the reporter and spell your last names, please.

8 MR. KRONEN: Gary Kronen, K-R-O-N-E-N

9 DR. FAKHOURI: Anton Fakhouri,
10 F-A-K-H-O-U-R-I.

11 MS. MURER: Cherilyn Murer, M-U-R-E-R.

12 CHAIRMAN GALASSIE: Thank you very much.
13 Collective swearing in.

14 (WITNESSES ARE SWORN)

15 CHAIRMAN GALASSIE: Thank you. Staff
16 report, please.

17 MR. CONSTANTINO: Thank you, Mr. Chairman.
18 The applicants are proposing to establish a limited
19 specialty ASTC providing orthopedics and plastic
20 surgery. Cost of the project is \$2.4 million. This
21 project received an intent to deny at the
22 January 2012 meeting. Additional information was
23 provided. No public hearing was requested. Letters
24 of support and opposition were received. The state

1 board findings remain unchanged. Eight hospitals
2 and 11 ASCTs are currently not at the 80 percent
3 target occupancy in the proposed geographic service
4 area. Thank you, Mr. Chairman.

5 CHAIRMAN GALASSIE: Thank you, sir. And who
6 would like to speak to the board.

7 MS. MURER: Thank you. We do appreciate
8 the opportunity to come back and clarify some of the
9 information that we brought forth in January. I
10 think the most important thing that we want to --
11 the most important point we want to make today is
12 the differentiation of this facility because of the
13 specialization in hand and upper extremity. Also
14 the differentiation related to trauma patients as
15 opposed to elective surgeries.

16 When we talk about underutilization of
17 other surgical centers in our area, these surgical
18 centers are primarily for elective surgeries and not
19 open for trauma patients. This facility will be
20 open approximately 76 hours a week.

21 You saw fit back in July of 2010 to take
22 the same types of circumstances for the Illinois
23 Hand and Upper Extremity Center in Arlington
24 Heights. There too was an underutilization of

1 facilities, but an approval of this hand and
2 surgical center.

3 We hope that you will take this precedence
4 today and allow a facility in the south suburbs to
5 serve patients in the the same way that you have
6 allowed patients in the northern suburbs to be
7 treated by this facility in Arlington Heights.

8 I will let the physicians also make
9 statements in regards to, in particular, the
10 specialization in upper extremity and hand.

11 CHAIRMAN GALASSIE: Thank you.

12 DR. FAKHOURI: Greetings, ladies and
13 gentlemen. It is very dangerous for me to grab the
14 microphone. I enjoy talking a lot. I will try and
15 keep it short.

16 I just want to bring a few points that are
17 very important to our specialty as a hand surgeon.
18 It is important to know that hand injuries affect
19 our society. There are 16 million hand injuries in
20 the United States, 6 million emergency room visits
21 per year and one out of every three of work-related
22 injuries are hand injuries resulting in 16 million
23 days of complete loss of work and 90 million days of
24 restricted work. That is staggering. 25 percent of

1 all work-related injury is related to hand injuries.
2 And of all the disability cases, one out of five are
3 related to hand. So when you think about it, it has
4 a huge impact on our state and country.

5 In fact, it is about \$10 billion of costs
6 associated with that hand conditions and injuries.

7 The issue here is also shortage of hand
8 surgeons in this country. Roseland Hospital doesn't
9 have a hand doc, so they are always looking around
10 to find people to take their hand cases and that is
11 the same of many of the hospitals in our area.

12 Only 10 percent of orthopedic physicians
13 specialize in hand surgery. There is a shortage of
14 fellowship trained hand surgeons in the United
15 States. As an example, in Illinois, only two in the
16 state of 11 million people graduate as fellowship
17 trained hand surgeons, two. As a result, we have a
18 real shortage. Combine that with the delays that we
19 see in the ER where patients are delayed in
20 treatment. And then, when they do come to us, by
21 the time they get to come to us it is days later and
22 we know from the literature, from European as well
23 as American literature, that delay in hand injuries
24 causes a tremendous amount of problems.

1 Complications in infection, stiffness, limitation in
2 motion and function often require a second
3 operation. It's best that, if you have a hand
4 injury such as a tendon laceration or fracture, to
5 deal with it right then and there and not to delay
6 it days later or even a week or two later, it is not
7 in the patient's best interest.

8 It is more cost effective to delay it.
9 And patients are not off work as long, off of school
10 as long, there are multiple bills involved, ER,
11 other private physicians or community services to
12 find a specialist. It doesn't make sense. It's the
13 right thing to do.

14 This shortage has a detrimental effect on
15 the quality of care of outcomes. And what has been
16 proposed by the American College of Surgeons and
17 other organizations, such as American Society of
18 Surgery of Plastics, as well as multiple
19 organizations from Europe as well as United States,
20 as well as a lot of literature, that really what
21 needs to be developed is a Hand Center of
22 Excellence. That is how you deal with these
23 particular cases.

24 We don't have any in Illinois. There is

1 one in Indiana, one in Louisville, Kentucky. We
2 don't have any in Illinois and we really need it.
3 We already have a facility that takes care of
4 everything except surgery suites. That will allow
5 us to take care of cut tendons and fractures, the
6 same thing, which is really what we need to do to
7 limit the complications and limit our costs
8 associated with these injuries.

9 Our goal in establishing the Palos Hills
10 Surgery Center is to develop a Center of Excellence
11 of Hand Surgery in concert with the Mid-America Hand
12 Clinic, which presently exists, where the totality
13 and coordination of expert hand care can be housed
14 in a single location for non-operative care of hand,
15 operative care as well as post operative care. It
16 is the best way to treat these patients.

17 With respect to opposition, none of the
18 hospitals in our area have opposed it in the GSA.
19 Many of them refer to us because we are the hand
20 surgeons in the area. So, for example, Metro South,
21 Ingalls, South Suburban Hospital, none of them have
22 coverage with hand surgeons they can call so there
23 is a real need in the community.

24 The hospital we attend is Christ Hospital.

1 Well, they are at 100 percent capacity both in the
2 ER as well as in the OR and, in fact, last year they
3 were on bypass 800 hours and they estimate on this
4 year they will be on bypass 1,100 hours so you can
5 see where hand sits with respect to the priority
6 when patients come into the ER. Not high priority
7 compared to chest pain, stroke and other patients
8 that come to the ER.

9 As far as Tinley Woods Surgery Center,
10 they have not opposed it. In fact, they have
11 supported it and they have 124 surgeons and what
12 they stated was that whatever cases that are not
13 done by us they can have other surgeons take our
14 spots. So that hasn't been an issue. And I believe
15 our impact to the hospital would be zero. Whatever
16 cases are taken to Christ Hospital, which is what
17 cases that we are doing now will continue. These
18 are high risk patients, the patients that have
19 severe injuries will continue. That will not impact
20 our hospital and I believe that this will be an
21 improvement for patients in our community as well as
22 the hospitals. Thank you very much.

23 CHAIRMAN GALASSIE: Thank you.

24 DR. KRONEN: To take the theme a little

1 further, Dr. Fakhouri did address the lack of impact
2 that approving a CON for PHFC will have on the
3 hospitals and surgery centers within our GSA. The
4 staffing committee reports said there is excess
5 capacity in our GSA. However, why is it that we
6 have such a difficult time obtaining operating room
7 at the ASTCs if there is excess capacity. Not only
8 in our elective operating schedule, but also for
9 urgent and emergent cases.

10 This occurs because ASTCs have
11 pre-determined hours of operations and schedules.
12 They close at 5:00 p.m. with no extended hours and
13 no on demand services. Therefore, no cases are
14 started after 2:30 p.m. so the center can close at
15 five. I've been in practice for 15 years and been
16 on staff at eight ambulatory surgery centers and all
17 of them have the same structure. There is no
18 flexibility. Therefore, by their self-imposed
19 structure, ASTCs are not utilized on a consistent
20 basis after 2:00 so that the center can close at
21 five.

22 Therefore, if you look at capacity
23 utilization, those three hours constitute somewhere
24 between 25 and 30 percent of the total time that

1 goes into their calculations. Furthermore, ASTCs
2 staffing and anesthesia needs are determined a day
3 prior to the next operating session. Most ASTCs do
4 not employ their own anesthesiologists, but use
5 those from universities and other hospitals so,
6 therefore, when the operating room schedule is
7 completed, they are gone, they return back to the
8 main center so they can complete the day's work over
9 there. Therefore, many operating rooms actually sit
10 unutilized because there is not staffing or
11 anesthesia with which we can come in and do our
12 urgent, emergent or add on type cases.

13 Before submitting to the board we
14 diligently looked at other ASTCs to meet our
15 patients' needs and they could not. Their general
16 response was no availability for extended hours of
17 operation, no call teams or second shifts. Their
18 employees work there because of limited hours which
19 the center is open which is very different than
20 hospital employees. General anesthesia cases must
21 be completed by 3 or 3:30 p.m. so the center can
22 close at five.

23 So what happens to the patient who cannot
24 have their fracture fixed the next day and is

1 scheduled for five or seven days later? As Dr.
2 Fakhouri said, more swelling, more scarring, more
3 time delay, more disability, more cost, increased
4 risk for secondary surgery when hand surgeries
5 cannot be treated as the true emergencies they truly
6 are.

7 How will PHFC increase access to care in
8 our community? Firstly, we will have extended hours
9 of operation 7:00 a.m. to 8:00 p.m Monday through
10 Friday with Saturdays hours between 7 and 1:00. Our
11 staffing and operating structure will be very
12 different where all staff and anesthesiologists are
13 employed by PHFC which will allow for us to provide
14 more services for elective, urgent and emergent
15 situations thereby increasing efficiency and access
16 to care and reducing recovery time.

17 Furthermore, we are committed to serving
18 the lower income population and increasing their
19 access to care in keeping with our obligation as
20 trauma physicians. Looking at our practice
21 demographics, we currently are approximately 5 to
22 10 percent Medicaid and we are credentialed and plan
23 to credential the team accrued. Please note that
24 none of the other ASTCs in our GSA accept Medicaid

1 as a form of insurance for the patient.

2 This would also allow us to pay more self
3 paying charity care. Self pay and charity
4 constitute approximately 5 percent of our practice.
5 Again, this is due to the high degree of trauma
6 services that we provide which is approximately
7 40 percent of the practice. When patients are seen
8 at area hospitals and referred for follow-up and
9 surgical care, the cost to utilize the hospital or
10 AFTC is often too much for these patients. With
11 PHFC, we would be able to refer these patients under
12 our charity care program. This also occurs not only
13 with patients who are uninsured, but those who have
14 only liability insurance that result in a personal
15 injury claim, Workers' Compensation, patients whose
16 claim is being arbitrated because it is in dispute.
17 We can take care of these patients now, get them
18 through their course of treatment and then, whatever
19 the determination is by an arbitrator, it is what it
20 is and this will most likely constitute a
21 significant part of reduced reimbursement or
22 ultimately charity care on part of defendant.

23 Unfortunately, definitive care delays also
24 increase the time for full recovery. That is

1 delayed treatment for hand conditions causing
2 increasing delays in reaching maximum medical
3 improvement. Prime example, carpal tunnel syndrome
4 typically four to six weeks for a patient to return
5 to full duty. When these claimants have their care
6 and delay, usually the recovery is on the realm of
7 four to six months due to the delays. You can
8 imagine the increased costs in partial disability
9 payments, medical costs. This ultimately increases
10 premiums for Workers' Compensation --

11 CHAIRMAN GALASSIE: Doctor, based on the
12 hour of the day, if I could ask you to wrap it up,
13 please.

14 DR. KRONEN: We ask the board to support
15 our application for a CON to establish a limited
16 specialty ASTC. We have determined to elevate the
17 level of hand surgical repair in our community by
18 improving efficiency, quality access.

19 Furthermore, we believe that we have
20 demonstrated that there is a need for additional
21 capacity based on evaluation of ASTC structure and
22 that we will increase access to care for patients
23 requiring urgent and emergent services as well as
24 for those who have difficulties in obtaining quality

1 medical and surgical care.

2 CHAIRMAN GALASSIE: Thank you. Questions on
3 behalf of board members?

4 DR. BURDEN: Are you a board certified
5 orthopedic surgeon? I wasn't here when you guys
6 started.

7 DR. FAKHOURI: I'm actually a board
8 certified plastic surgeon as well as a board
9 certified hand surgeon. I do not do plastic
10 surgery. My entire practice is hand surgery. The
11 issue is that hand surgery falls under both plastic
12 surgery and orthopedics. That is why the limited
13 specialty is requesting the two based on my
14 certification.

15 DR. BURDEN: Now, personally, Terry Light
16 and I go back a long time. His dad's an
17 ophthalmologist. I think he is the premier hand
18 surgeon in town. Who did you train with?

19 DR. FAKHOURI: Yes. I trained at UCLA in
20 California by Roy Neels and Terry Light when I was a
21 medical student and I respect him.

22 DR. BURDEN: And your training?

23 DR. KRONEN: My training was micro surgery
24 at the University of Louisville and then a hand

1 surgery fellowship at Baylor College of Medicine in
2 Houston, Texas.

3 DR. BURDEN: I wasn't here the last time. I
4 listened to your explanation. I think maybe we have
5 an advocate for to you who works at Roseland
6 Hospital who made a plea. I was impressed that you
7 guys are going to stay open. You entertain being
8 available for emergencies from an ER without
9 evidence that the patient has coverage. Did I hear
10 that clearly?

11 DR. KRONEN: Yes.

12 DR. BURDEN: Excuse me for being so
13 personal. You are one of the first Iranian surgeons
14 who hasn't become a vascular surgeon or heart
15 surgeon. That is what they did so you must be
16 talented.

17 DR. FAKHOURI: Well, I enjoy my area of
18 specialty. Thank you, I'm not Iranian, but close in
19 the region, Jordanian.

20 DR. BURDEN: Just over the border.

21 MR. SEWELL: I wanted to clarify some
22 things. I don't know why I always ask questions of
23 the staff first, but this thing we did in January, I
24 think the Arlington Heights situation, was that a

1 limited specialty ambulatory surgery treatment
2 center that will pretty much do hand and is that
3 what is presented to us is that the other providers
4 in the area that have not met the occupancy
5 standard.

6 MR. CONSTANTINO: Yes.

7 MR. SEWELL: So, essentially, we kind of
8 carved out and recognized the uniqueness of this as
9 an intervention and so this applicant is asking us
10 to do the same pretty far away south.

11 MR. CONSTANTINO: Mr. Sewell, we don't
12 compare projects. We don't do a comparative review.
13 That is why that project was never brought to your
14 attention. We consider each project on its own
15 merits.

16 MR. SEWELL: Oh, no, it wasn't brought to my
17 attention by you in the staff report, but the
18 applicant brought it to my attention.

19 MR. CONSTANTINO: The staff didn't bring it
20 to your attention because we don't do comparative
21 reviews. We are not allowed to.

22 MR. SEWELL: No, I understand, but you have
23 to think about that in terms of what that means for
24 the care of patients that have a need for this

1 rather specialized intervention. So could there be
2 -- has there been any thought given to a specialty
3 category where the surgeries are confined to one
4 thing and, if we compare them with each other, then
5 we can do sort of community need for that
6 intervention and the issue of the occupancy or the
7 other facilities would not come into play.

8 MR. CONSTANTINO: We have never discussed
9 that as part of any new rules and what you're
10 suggesting. As the rules are currently written
11 right now, we look at the capacity within the
12 identified geographic service area.

13 MR. SEWELL: In a situation like this, I'm
14 inclined to support something like this just because
15 of the reality of the need for it because to look at
16 others it would be comparing apples and oranges but
17 it is a different kind of thing. But, in doing
18 that, of course, if I voted for it, I would violate
19 the rules which I don't really care about.

20 MR. CONSTANTINO: So you have wide
21 discretion how you want to vote.

22 CHAIRMAN GALASSIE: Any other questions from
23 board members.

24 MS. OLSON: I have one quick comment. I was

1 very disappointed when we did not pass this for all
2 the reasons that you just stated and I am even more
3 pleased that you are coming back to the table
4 telling us that you are willing to take Medicaid
5 patients, patients that need care right now and
6 ultimately at a less cost and not only less cost in
7 needed health care cost, but the long-term cost of
8 work disability and all of those things.

9 CHAIRMAN GALASSIE: Well said.

10 MR. HAYES: I have a question. This project
11 is for a limited specialty clinic. So you are not
12 going to increase to another specialty. That is not
13 going to come in. You have to come to the board
14 before you would do that?

15 DR. KRONEN: That's correct.

16 CHAIRMAN GALASSIE: Any other questions?

17 (NO RESPONSE)

18 CHAIRMAN GALASSIE: Hearing none, do I have
19 a motion to approve Project 11-095 for the
20 establishment of a limited specialty ASTC in Palos
21 Hills?

22 MS. OLSON: So moved.

23 DR. BURDEN: Seconded.

24 CHAIRMAN GALASSIE: Moved and seconded.

1 Roll call, please.

2 MR. ROATE: Motion made by Ms. Olson,
3 seconded by Dr. Burden. Dr. Burden?

4 DR. BURDEN: I will vote yes based on
5 everything I heard today.

6 MR. ROATE: Mr. Eaker?

7 MR. EAKER: I've heard some new things
8 today. I'm still reluctant in a few areas, but I'll
9 vote yes, sir.

10 MR. ROATE: Justice Greiman?

11 MR. GREIMAN: Yes.

12 MR. ROATE: Mr. Hayes?

13 MR. HAYES: Yes.

14 MR. ROATE: Mr. Hilgenbrink?

15 MR. HILGENBRINK: Yes.

16 MR. ROATE: Ms. Olson?

17 MS. OLSON: Yes.

18 MR. ROATE: Mr. Sewell?

19 MR. SEWELL: Yes.

20 MR. ROATE: Chairman Galassie?

21 CHAIRMAN GALASSIE: Yes.

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

24 CHAIRMAN GALASSIE: Motion carries.

1 Congratulations. Thank you very much.

2 Folks, it is ten to five and we have a few
3 items left on our agenda. I will recommend taking
4 executive session and putting that at the end of the
5 agenda, so that if staff don't want to stay, they
6 don't have to because they will not be required,
7 actually they won't be allowed in executive session.

8 So we will then move on to items number 9
9 through 13. We will then allow staff to depart and
10 we will have a brief executive session. I think we
11 should be done here within 45 minutes for those of
12 you traveling.

13 Item nine, compliance of issues. I will
14 not take a formal break if anybody here needs to
15 stretch. Frank, you're up.

16 MR. URSO: In regards to compliance issues,
17 that will have to be following the executive session
18 after we do the executive session, so we can go
19 right into other business of legislative update.

20 CHAIRMAN GALASSIE: So be it.

21 MR. URSO: In one of your hand-outs is this
22 landscape document that has number of bills on it.
23 That is what I will talk about. As you probably
24 already noticed, I'm not Alexis. She is in

1 Springfield with Courtney on other business today,
2 so unfortunately, they are not here. What I want to
3 do is just briefly talk about some of the bills that
4 the legislature is looking at.

5 So if you will take a look at that
6 landscape document, I will be talking about this
7 document here. These are 11 bills that were
8 introduced during this legislative session that
9 impact the board one way or another.

10 So the first one Senate Bill, SB means
11 Senate Bill, 2934. That is a bill that was
12 introduced by Senator Garrett. We assisted Senator
13 Garrett in the drafting of that particular bill and
14 that has a number of different amendments on it that
15 clarify, streamline and explain portions of the
16 Health Facilities Planning Act hopefully in a much
17 more understandable fashion.

18 By the way, if any board member or
19 ex-officio wants a copy of any of these bills, we
20 will send them to you if you want to take a look at
21 those. So senate bill is essentially a bill that
22 was in committee this morning and that is why
23 Courtney and Alexis weren't here and that bill
24 passed through the Senate committee and is now

1 moving to the floor. So we are pleased with the
2 movement of Senate Bill 2934.

3 MR. EAKER: As was written or amended?

4 MR. URSO: It has been amended. The
5 compensation piece was moved out into an independent
6 bill, as well as there is some clarification on the
7 compliance section.

8 Senate Bill 2887 is a bill introduced by
9 Senator Steans and there is a parallel House Bill
10 4563 that was introduced by Representative Riley.
11 Both of those bills in a nutshell remove from the
12 board's jurisdiction the ID/DD facilities. There
13 are about 200 of those facilities in the state. Our
14 position is in opposition to that particular bill.

15 DR. BURDEN: What is IDDD?

16 MR. URSO: Intellectually Disabled and
17 Developmentally Disabled individual. This is the
18 first time this type of group has tried to remove
19 itself from the board's jurisdiction. We are in the
20 process of letting it be known through a position
21 paper that we oppose that, so that one is still
22 pending.

23 MR. SEWELL: So when there is an opposal to
24 these things with capital investment, who approves

1 it or are they just on their own? In other words,
2 like not having a certificate of need if you're one
3 of these things.

4 MR. URSO: There has to be a fiscal note
5 that will come along. As soon as that gets in a
6 different stage, there will be a fiscal note to see
7 what the impact is. In fact, I should tell you --
8 I'm sorry.

9 MS. OLSON: That did not get heard at 11:00
10 this morning?

11 MR. URSO: No. In fact, tomorrow, Courtney,
12 myself and Alexis have a meeting with Senator Steans
13 to talk about this bill and to clarify for her why
14 we are in opposition to it and hopefully we can get
15 an understanding as to why we think this is
16 important for the board to continue to have
17 jurisdiction over these types of facilities.

18 MR. JONES: Frank, I think, the question I
19 heard from Richard was, if these passed, would these
20 facilities be out of the venue and the answer is
21 yes.

22 MR. SEWELL: Yes.

23 MR. URSO: If that was your question, I'm
24 sorry.

1 MR. SEWELL: Well, I was asking a little
2 more than that. I said what would happen and he
3 said there would have to be a fiscal note. Did you
4 say that?

5 MR. URSO: Yes, I did.

6 MR. JONES: What does that mean?

7 MR. URSO: Member Sewell asked the question
8 about a financial impact.

9 MR. SEWELL: That's right.

10 MR. URSO: And what I said is there will
11 have to be a financial impact note at some point at
12 how perhaps the board may lose revenue or whatever
13 the financial impact may be if this bill is
14 approved.

15 MR. JONES: So you're telling us that
16 somebody would have to write a fiscal note about the
17 impact of the bill?

18 MR. URSO: That's correct.

19 MR. JONES: But that has nothing to do with
20 the facility building itself out there in the real
21 world after this passes?

22 MR. SEWELL: See, that's what I'm trying to
23 get at. What happens when this passes and then
24 someone wants to do intellectually disabled --

1 MR. URSO: A DD facility.

2 MR. SEWELL: And facility, nothing happens,
3 right? They just do it if they want to.

4 MR. URSO: The only monitor is the Illinois
5 Department of Public Health in terms of licensure.

6 MR. SEWELL: Okay. So it is like being in a
7 state that doesn't have CON if you have one of
8 these?

9 MR. URSO: Correct. They will be exempt
10 from review of this board. Sorry about the
11 misunderstanding. Are you okay, Mike?

12 MR. JONES: I think so.

13 MR. URSO: The next one is Senate Bill 3608
14 and this is a bill that was introduced by Senator
15 McCarter and Senator Brady and it essentially says
16 that the board will be dissolved and the terms of
17 the members will cease after July 1st, 2013. That
18 particular bill wasn't -- was on the agenda for
19 committee today, but that bill was not called. And,
20 of course, we are in opposition to that bill.

21 DR. BURDEN: He's been hollering for that.

22 MR. URSO: Senate Bill 3614 is a bill that
23 was introduced by Senator Sullivan. This has to do
24 with creating a bed exchange program in Illinois.

1 Courtney and I and Alexis had an opportunity to
2 speak with Senator Sullivan and explain to him that
3 this board has created -- well, legislature has
4 created a long term care subcommittee and that
5 subcommittees has created a work group and they are
6 talking about this very issue and they are in the
7 middle of researching it and determining what the
8 pluses and the minuses are for a bed exchange
9 program and we explained that to Senator Sullivan
10 that this bill is premature. So this bill was also
11 up for committee call this morning and that did not
12 get out of committee also and we are opposed to that
13 particular bill.

14 The next one, is House Bill 4563.

15 MR. SEWELL: The SB 2887.

16 MR. URSO: Yes. That is the same thing as
17 the 287 one. They are both the same. One is in the
18 House and one is in the Senate. The wording on
19 those is identical. So we go to House Bill 1429.
20 That was introduced by Representative Flowers and
21 that has to do with written notice and reports must
22 be provided by a hospital. If there is a reduction
23 in service by 25 percent rather than what it says in
24 the statute right now is 50 percent. So we are on

1 neutral on that particular bill.

2 MR. SEWELL: What happened to it?

3 MR. URSO: That one hasn't come up for
4 hearing unless it came up this afternoon and we
5 don't have any messages from our cohorts, do we.
6 House Bill 5142 is a bill introduced by the Co-Chair
7 of the Health Reform Task Force, Representative
8 Dugan, and what that does is essentially opens up
9 the free standing emergency centers once again to
10 the board's jurisdiction and allows applicants to
11 come before the board with a free standing emergency
12 center application until 2014 and we are in neutral
13 on that particular bill.

14 House Bill 5668 was introduced by
15 Representative Cassidy and Representative Harris and
16 this bill essentially re-institutes the board's
17 jurisdiction over long term care facilities if there
18 is a change of ownership. Not only long term care
19 facilities, but the ID/DD facilities would also have
20 to come back before this board if they wanted to
21 change ownership.

22 Currently, the statute removed them from
23 the board's jurisdiction. This would be putting
24 them back under the board's jurisdiction and it was

1 yesterday that Alexis and I met with Representative
2 Cassidy and told her we are very much in support of
3 this bill and she gave us some of the background in
4 terms of why she introduced it and, like I said, we
5 are in support of that particular bill.

6 House Bill 5775 was introduced by
7 Representative Phelps and this bill essentially
8 removes the VA long term care facilities. The
9 Veterans Administration long term care facilities
10 from the board's jurisdiction. We are neutral on
11 that particular bill.

12 Now, just for a point of reference, it's
13 been a number of years since we've had a VA
14 application in front of us. Michael, I want to say
15 2009 maybe, 2010? It's been a long time so we don't
16 see a lot of VA applications to begin with.

17 DR. BURDEN: We had one that hung around
18 forever.

19 MR. URSO: We have some client issues that
20 were in the final stages of working out but, other
21 than that, we don't see them very often.

22 The other two bills, Senate Bill 2866 and
23 Senate Bill 3145 are both shell bills. So
24 essentially those are just bills where there is a

1 grammatical change made or just a word is changed or
2 removed and the thought is those are bills that are
3 held in place in case somebody wants to come and
4 make some more changes with the Act or make some
5 amendments on some other bills, so that is just a
6 holding bill essentially. So those are all the
7 bills that have been introduced in this session that
8 impact the board. Are there any questions?

9 CHAIRMAN GALASSIE: Do you want this sheet
10 back?

11 MR. URSO: No.

12 MR. GREIMAN: Are you amending one of the
13 bills at the bottom to bring huge compensation to
14 the board?

15 MR. CONSTANTINO: I can't answer that,
16 Judge. I don't know. It's a good thought and it's
17 on the transcript.

18 MR. URSO: Mr. Chair, do you want to move to
19 rules development? Claire is here to present the
20 rule changes and give you some information on the
21 1130 bills. Claire, this is on.

22 MS. BURMAN: I will try to keep this
23 brief. Hopefully everyone received the summary of
24 substantive changes. It is a chart.

1 CHAIRMAN GALASSIE: What are you asking us,
2 Claire?

3 MS. BURMAN: I'm asking if you received the
4 summary. Just to summarize the summary, we have
5 amended 1130 which are the procedural rules for the
6 board and that was done for a couple of reasons.
7 One is to get it up to date with changes to the Act
8 that occurred a couple of years ago.

9 The other reasons were to organize a
10 little bit better and refine some of the language
11 for points of clarification, so it was sort of like
12 a cleaning up of this part of your rules. Some of
13 the activities that happened were to add a couple of
14 new sections and subsections and an example would be
15 -- can't read my writing.

16 We have a new section that appears a
17 couple of times in these rules that refers to the
18 public participation at the board formal meetings.
19 We have it in a couple of rules because it actually
20 acts as a reference book for the applicant rather
21 than a novel. No one is likely to read everything
22 from page 1 through to page 129. So we have it in a
23 couple of places where we get people who are looking
24 for that kind of information.

1 We also have some new sections both for
2 permit and for exemptions that describe any
3 activities that would lead to the revocation of a
4 permit or an exemption and relinquishment of a
5 permit or exemption. There is a separate section
6 for that.

7 We have also consolidated all of the fees.
8 We have updated the fees themselves but we have
9 consolidated them in one section so that those are
10 easier to find in the rules as an easy reference.

11 And there is another new item. We are
12 proposing to replace the permit letter with a permit
13 agreement letter which consolidates all of the post
14 permit requirements for a permit holder or an
15 exemption holder and then a signature is required by
16 both parties and, basically, it is an acknowledgment
17 that they understand that these are expected things
18 that follow the receiving of a permit or exemption,
19 so that is something new too. I don't know if Frank
20 wanted to speak more of this.

21 CHAIRMAN GALASSIE: What is the status of
22 this?

23 MS. BURMAN: This is a draft. If you
24 approve it today, then we can go to first notice in

1 maybe a month's time.

2 MR. SEWELL: I'm on page 1, 1130-130. That
3 last bullet, why does that have as our purpose to
4 assess the financial burden to patients caused by
5 unnecessary health care construction and
6 modification. Why is it just patients?

7 MS. BURMAN: That is the language in the
8 Act.

9 MR. SEWELL: That is an odd thing because,
10 even if you are not a patient, you have a financial
11 burden from unnecessary health care construction and
12 modification.

13 MS. BURMAN: But the changes to the Act were
14 put together by a multitude of people so it is like
15 a grand cut and paste and hope for the best. So
16 anything like that where there is a citation after
17 it is language from there.

18 And you can see under definitions we have
19 some new definitions. Most of those were added
20 because we thought that they would be helpful. Some
21 have been amended. Just based on usage of them and
22 the need for some refinement and there are a few
23 that were deleted. Either they don't count any more
24 like executive secretary or HFPD or the state board

1 or impending. Impending was taken out because that
2 was tied in with the letter of intent.

3 CHAIRMAN GALASSIE: Claire, can you give me
4 a minute on 1130 regarding public comment
5 procedures. The wording that has changed there.

6 MS. BURMAN: Which section of it?

7 CHAIRMAN GALASSIE: 1130.995. Very last one
8 on the spreadsheet.

9 MS. BURMAN: These are procedures that we
10 put together for the public participation at these
11 board meetings. And we are trying to discourage
12 repetition of anything you've already heard or read.

13 CHAIRMAN GALASSIE: Claire, I want to go
14 back to that very last thing. We were talking about
15 public comment. My sense is you are hoping we would
16 adopt this today, so we could start moving forward.

17 My only reservation is this specific item,
18 while we have qualified to an extent, we are still
19 under dialogue with the AG's office as to whether or
20 not we have to have public comment at the board
21 meeting and I'm hesitant to have the board approve
22 this until we have that next dialogue because,
23 again, the whole discussion we have, the opportunity
24 for public hearings prior to this, now we come to a

1 board meeting with no concept of is there going to
2 be 4 comments or 40?

3 So I feel very strongly that there are few
4 boards that I know of, there are no boards that I
5 know of that establish an agenda not knowing what
6 extent of time the public is going to demand, so I
7 will work aggressively and ask the staff to assist
8 me with the AG's office to interpret that at a board
9 meeting public comments. A board meeting is not the
10 appropriate place for public comments. That should
11 be taking place prior to public hearings.

12 MR. URSO: I think there are two options. I
13 think one option is you can approve the rules with
14 that excluded, just take that part out, or you can
15 approve the whole thing and this is a working
16 document all the time. In fact, we are already
17 probably after you approve this, we will probably
18 start working on revising some of it anyway,
19 especially if Senate Bill 2934 gets approved, we're
20 going to change these rules. So, in other words,
21 this is always a dynamic work in progress, so I
22 guess there are two ways you can do it.

23 CHAIRMAN GALASSIE: Well, I don't want to
24 lose sight of this is very high on the priority list

1 for us to accomplish, so I guess I would suggest we,
2 as a board, adopt this today excluding this last
3 section but knowing amongst ourselves we will work
4 diligently to address this in the next couple of
5 months. That having been said --

6 MS. BURMAN: Does that mean you want me to
7 take that section out?

8 CHAIRMAN GALASSIE: You know, you can leave
9 the section in, but I guess I just want us to
10 understand what I've done with it, so we can approve
11 this as is.

12 MS. BURMAN: I think that's fine. I will
13 double check with JKR and give them a call and help
14 them to understand the reason why that could occur.

15 CHAIRMAN GALASSIE: Okay. Well, you tell
16 me. I think you are hearing what our intent is to
17 accomplish. What's easier for all of us or really
18 you for us to do today to hopefully get to where we
19 want to on this issue in the next couple of months?

20 MS. BURMAN: You can approve it with the
21 contingency that, if the requirement for having this
22 in there changes, that we would just be able to
23 delete it before everything is filed.

24 CHAIRMAN GALASSIE: How about a motion,

1 ladies and gentlemen, that we accept the recommended
2 changes to our code with the condition that item
3 1130.995 --

4 MS. BURMAN: It is in three places.

5 CHAIRMAN GALASSIE: Okay. Well, with the
6 condition that this last item may well change
7 subsequent to our further dialogue with the Attorney
8 General's Office.

9 MR. HAYES: So moved.

10 MR. BURDEN: Second.

11 CHAIRMAN GALASSIE: Do we need a roll?

12 MR. URSO: No.

13 CHAIRMAN GALASSIE: All in favor?

14 (AYES HEARD)

15 CHAIRMAN GALASSIE: All opposed? Hearing
16 none, thank you. Well done, Claire.

17 Moving forward, no old business, how about
18 some monkey business, no we got new business.

19 MR. URSO: Mr. Chair, let me address the
20 first three items under new business. This board
21 has three requirements that need to be done before
22 the next meeting. The next meeting is April 17,
23 2012.

24 First one is open meetings training. This

1 is a new statutory requirement for public bodies.
2 You should have in front of you a cover sheet, as
3 well as an instruction sheet on the second page that
4 tells you how to access the Attorney General's
5 website and essentially take the training and then,
6 once you complete it, you need to print the
7 certificate of completion and then please send it
8 back to me so I can file it and we can account for
9 everyone on the board taking the statutory Open
10 Meetings Act training. I have taken it. I have
11 followed these instructions and I've given them to
12 other people and said tell me if this works. If
13 anybody has any problems, please call me.

14 CHAIRMAN GALASSIE: Are you going to give us
15 an e-mail telling us what to do on this?

16 MR. URSO: That is what this document is.
17 Does everybody have a copy of the document?

18 MR. GREIMAN: Where is the Attorney
19 General's website, where is that listed?

20 MR. URSO: That is number one on the
21 instructions on the second page. You go into
22 Illinois Attorney General dot gov.

23 MR. BURDEN: Thank you, I see it.

24 MR. URSO: So what I'm asking you is that

1 you complete this training before or at our next
2 meeting, before our next meeting April 17, 2012 and
3 you can always send the certificate to me by e-mail,
4 by hard copy or hand it to Cathy or I at the next
5 meeting. That's the Open Meetings Training. Any
6 questions on that?

7 MS. OLSON: Half hour? Hour? How long does
8 it take to do it?

9 MR. URSO: It is about 60 items as I recall.
10 It is 62 slides. It probably took me a half hour
11 because you can't rush through it. They won't let
12 you. Okay.

13 The second thing I want to talk about is
14 filing of Statement of Economic Interest and all
15 boards members have done this previously. The
16 Statement of Economic Interest will be mailed to
17 your home addresses on or about March 17. You need
18 to complete it, fill in all the items and, please,
19 send it back to me and then I will mark it off and
20 then I will send it to the Secretary of State. So
21 I'm asking that you, please, get back to me before
22 or on April 17 which is our next meeting. That is
23 the Statement of Economic Interest and that will be
24 mailed to your homes. So if you see something like

1 that, don't throw it away.

2 The third item is the ethics training and
3 this is the annual ethics training so we've been
4 doing this annually for a number of years now. I've
5 given you a cover sheet as well as the paper copy of
6 the training. So you need to read the training and
7 then sign the certificate on the last page. It is
8 the acknowledgment of participation on page 39.
9 Then you need to get that page back to me. And I'm
10 asking that you also get that back to me on or
11 before the April 17 meeting.

12 So we have three items. One you have to
13 go to the Internet. That's the open meeting
14 training, the Statement of Economic Interest is
15 coming to your house and the ethics training is on
16 your desktop right now. Not your computer desktop,
17 on where you're sitting. So you need to get three
18 items back to me on or before or on April 17. If
19 you have any questions, don't hesitate to call me
20 especially if you have a hard time getting into the
21 Attorney General's website. They made it very user
22 friendly as soon as you can find it. It is located
23 on their home page.

24 Dr. Burden, don't hesitate to call me.

1 Mr. Chair, that is all I have in terms of new
2 business.

3 CHAIRMAN GALASSIE: Thank you. The rest of
4 the items were Village Inn of Cobden discontinued.

5 MR. URSO: Mike, that's you?

6 MR. CONSTANTINO: Yes. Item four, Village
7 Inn of Cobden discontinued to 16 bed ICF facility.
8 We need a board approval for that to take it out of
9 the inventory. We also provided in your packet the
10 January of 2012 financial report.

11 CHAIRMAN GALASSIE: Let me stop, Mark. Do
12 you want a motion for this number four, Village Inn?

13 MR. CONSTANTINO: What do you think, Frank,
14 just a voice vote?

15 MR. URSO: Voice vote is fine.

16 CHAIRMAN GALASSIE: So a motion to remove
17 the Village Inn Cobden from our inventory.

18 MR. CONSTANTINO: The board's inventory.

19 MR. GREIMAN: Second.

20 CHAIRMAN GALASSIE: Moved and seconded. All
21 in favor?

22 (Ayes heard)

23 CHAIRMAN GALASSIE: All opposed?

24 (No response)

1 CHAIRMAN GALASSIE: Hearing none, motion
2 passes.

3 MR. CONSTANTINO: Then the last item number
4 six we had four 2010 profile changes. Again, I ask
5 the board to give a voice vote to approve these
6 changes. They are relatively small. Most of them
7 were just transposition of numbers in their report
8 to us. They notified us and gave us an explanation
9 of why it happened.

10 CHAIRMAN GALASSIE: Motion to approve
11 profile changes as recommended?

12 MR. SEWELL: So moved.

13 MR. HAYES: Second.

14 CHAIRMAN GALASSIE: Moved for second and all
15 in favor? Opposed? Hearing none, thank you.

16 Very good. We are now at the point of
17 going into executive session. We will ask who do we
18 want in executive session.

19 MR. URSO: Staff.

20 CHAIRMAN GALASSIE: Staff initially will
21 remain. Anyone other than of staff or board
22 members, thank you very much.

23 Motion to executive session pursuant to
24 Sections 2C1, 2C5 and 2C11 of the Open Meetings Act.

1 MS. OLSON: So moved.

2 MR. HAYES: Second.

3 CHAIRMAN GALASSIE: All in favor?

4 (Ayes heard)

5 CHAIRMAN GALASSIE: We are in executive
6 session. Microphones are off.

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8 End Time 5:27 p.m.

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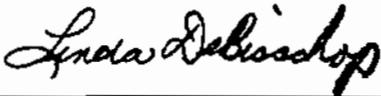
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CERTIFICATE OF REPORTER

I, Linda DeBisschop, Certified Shorthand Reporter, Notary Public within and for the States of Illinois and Missouri, do hereby certify that the proceedings in the above-entitled cause were taken by me to the best of my ability and thereafter reduced to writing; that I am neither counsel for, related to, nor employed by any of the parties to the action, and further that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.



Linda DeBisschop, CCR-MO, CSR-IL

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