

1 S100921

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

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8 REPORT OF PROCEEDINGS
9 Bolingbrook Golf Club
10 2001 Rodeo Drive
11 Bolingbrook, Illinois 60490
12 July 14, 2014
13 9:04 a.m. to 2:34 p.m.

14 BOARD MEMBERS PRESENT:

- 15 MS. KATHY OLSON, Chairperson;
- 16 MR. JOHN HAYES, Vice Chairman;
- 17 MR. PHILIP BRADLEY;
- 18 MR. DALE GALASSI;
- 19 JUSTICE ALAN GREIMAN; and
- 20 MR. RICHARD SEWELL.

21
22
23 Reported by: Melani e L. Humphrey-Sonntag,
24 CSR, RDR, CRR, CCP, FAPR
Notary Public, Kane County, Illinois

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EX OFFICIO MEMBERS PRESENT:

MR. DAVID CARVALHO, IDPH;
MR. MATT HAMMOUDEH, IDHS; and
MR. MIKE JONES, IDHFS.

ALSO PRESENT:

MR. FRANK URSO, General Counsel ;
MS. COURTNEY AVERY, Administrator;
MS. CLAIRE BURMAN, Rules Coordinator;
MS. CATHERINE CLARKE, Board Staff;
MR. MICHAEL CONSTANTINO, IDPH Staff;
MR. BILL DART, IDPH Staff; and
MR. GEORGE ROATE, IDPH Staff.

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1 CHAIRPERSON OLSON: I'm going to call
2 this meeting to order.
3 May I have a roll call, please.
4 MR. ROATE: Mr. Hayes.
5 VICE CHAIRMAN HAYES: Here.
6 MR. ROATE: Mr. Bradley.
7 MEMBER BRADLEY: Here.
8 MR. ROATE: Dr. Burden.
9 (No response.)
10 MR. ROATE: Absent.
11 Senator Demuzio.
12 (No response.)
13 MR. ROATE: Absent.
14 Mr. Galassi.
15 MEMBER GALASSI: Present.
16 MR. ROATE: Justice Greiman.
17 MEMBER GREIMAN: Present.
18 MR. ROATE: Mr. Penn.
19 (No response.)
20 MR. ROATE: Absent.
21 Mr. Sewell.
22 MEMBER SEWELL: Here.
23 MR. ROATE: Ms. Olson.
24 CHAIRPERSON OLSON: Present.

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1 So that makes six members?

2 MR. ROATE: Yes. Six present, ma'am.

3 CHAIRPERSON OLSON: Okay. The next
4 order of business is executive session.

5 May I have a motion to go into executive
6 session pursuant to Section --

7 MEMBER GREIMAN: So moved.

8 MEMBER GALASSI: Second.

9 CHAIRPERSON OLSON: I have a motion and
10 a second to go into closed session pursuant to
11 Sections 2(c)(1), 2(c)(5), 2(c)(11), and 2(c)(21) of
12 the Open Meetings Act.

13 May I have a voice vote?

14 VICE CHAIRMAN HAYES: So moved.

15 CHAIRPERSON OLSON: I have a first and
16 second.

17 MEMBER GALASSI: Aye.

18 MEMBER HAYES: Aye.

19 CHAIRPERSON OLSON: Everybody in favor
20 say aye.

21 (Ayes heard.)

22 CHAIRPERSON OLSON: Opposed, I like sign.

23 (No response.)

24 CHAIRPERSON OLSON: We're now in

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1 executive session for approximately half an hour.

2 We'll need everybody to clear the room,
3 please.

4 (At 9:05 a.m., the Board adjourned
5 into executive session. Open
6 session proceedings resumed at
7 9:33 a.m., as follows:)

8 CHAIRPERSON OLSON: I'm going to call
9 the meeting back to order.

10 The next order of business is compliance
11 issues, settlement agreements, and final orders.

12 Frank?

13 MR. URSO: Thank you, Madam Chair.

14 There are four health care facilities that
15 we are going to be requesting to be referred to the
16 legal department for review for compliance matters,
17 and so we're looking for a motion to refer these
18 matters for review and filing of any notices of
19 noncompliance, which may include sanctions detailed
20 and specified in the Board's acts and the Board's
21 rules.

22 CHAIRPERSON OLSON: May I have a motion?

23 MEMBER GALASSI: So moved.

24 MEMBER BRADLEY: Seconded.

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1 VICE CHAIRMAN HAYES: Second.

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

4 (Ayes heard.)

5 CHAIRPERSON OLSON: Opposed, like sign.

6 (No response.)

7 CHAIRPERSON OLSON: Motion passes.

8 MR. URSO: Let me just specify, for the
9 record, those four facilities are Daystar Care Center
10 in Cairo, Illinois; Bridgeview Health Care in
11 Bridgeview, Illinois; Parker Nursing and Rehab Center
12 in Streator, Illinois; and Roseland Community Hospital
13 in Chicago, Illinois.

14 Those are the four facilities.

15 CHAIRPERSON OLSON: Thank you.

16 Final orders?

17 MR. URSO: Madam Chair, I want to offer
18 to the Board an opportunity to issue a final order on
19 the Mercy Crystal Lake Hospital and Medical Center,
20 Project 10-089 -- and docket number is HFSRB 12-10 --
21 and a motion to adopt the Administrative Law Judge's
22 report, findings, and recommendations.

23 CHAIRPERSON OLSON: May I have a motion
24 to support the Administrative Law Judge -- oh, did

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1 you -- adopt.

2 VICE CHAIRMAN HAYES: So moved.

3 MEMBER GALASSI: Second.

4 CHAIRPERSON OLSON: And I think we'll do
5 a roll call vote on this one.

6 MR. ROATE: Mr. Hayes.

7 VICE CHAIRMAN HAYES: Yes.

8 MR. ROATE: Mr. Bradley.

9 MEMBER BRADLEY: Yes.

10 MR. ROATE: Mr. Galassi.

11 MEMBER GALASSI: Yes.

12 MR. ROATE: Justice Greiman.

13 MEMBER GREIMAN: Yes.

14 MR. ROATE: Mr. Sewell.

15 MEMBER SEWELL: Yes.

16 MR. ROATE: Chairwoman Olson.

17 CHAIRPERSON OLSON: Yes.

18 MR. ROATE: That's 6 votes in the
19 affirmative.

20 CHAIRPERSON OLSON: The motion passes.

21 Anything else?

22 MR. URSO: Thank you, Madam Chair.

23 That's all I have.

24 CHAIRPERSON OLSON: The next order of

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1 business is approval of the agenda.

2 May I have a motion to approve the agenda?

3 VICE CHAIRMAN HAYES: So moved.

4 CHAIRPERSON OLSON: And a second?

5 MEMBER BRADLEY: Second.

6 CHAIRPERSON OLSON: All in favor

7 say aye.

8 (Ayes heard.)

9 CHAIRPERSON OLSON: Opposed, like sign.

10 (No response.)

11 CHAIRPERSON OLSON: Motion passes. The
12 agenda is approved.

13 May I have a motion to approve the
14 transcripts from the June 3rd, 2014, meeting?

15 MEMBER GALASSI: So moved.

16 VICE CHAIRMAN HAYES: Second.

17 CHAIRPERSON OLSON: All in favor

18 say aye.

19 (Ayes heard.)

20 CHAIRPERSON OLSON: Opposed, like sign.

21 (No response.)

22 CHAIRPERSON OLSON: The motion carries.

23 (Discussion off the record.)

24 MEMBER GALASSI: They're discussing

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PUBLIC PARTICIPATION**

11

1 Lunch.

2 CHAIRPERSON OLSON: Yeah.

3 The next order of business is public
4 participation.

5 Courtney.

6 Please remember that, when you do public
7 participation, you need to spell your name for the
8 court reporter and sign the pad, and everybody will be
9 given two minutes.

10 Where's my timekeeper?

11 MR. ROATE: Did you want me to keep
12 time?

13 CHAIRPERSON OLSON: George will tell you
14 loudly when your two minutes are up.

15 MEMBER GREIMAN: Madam Chair, could you
16 talk into your microphone?

17 CHAIRPERSON OLSON: I'm sorry.

18 MEMBER GREIMAN: We can't hear.

19 CHAIRPERSON OLSON: I said that George
20 will tell them loudly when their two minutes are up.

21 MEMBER GREIMAN: That's good. You do
22 good.

23 MS. AVERY: Okay. So the first
24 application for public participation is the University

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1 of Chicago Medical Center, and we have Marti Smith and
2 Veronica Morris Moore.

3 CHAIRPERSON OLSON: Please come to the
4 table.

5 MR. CONSTANTINO: Please sign in.

6 Can you sign that yellow sheet? That yellow
7 pad -- can you put your name on the yellow pad?

8 CHAIRPERSON OLSON: Just a reminder that
9 your comments need to be limited to the application.

10 One more thing before you start: There was
11 a two-page document sitting on our table that was
12 passed out before the meeting. That document has been
13 pulled and will be shredded. None of the Board
14 members have reviewed that document.

15 That is counted as ex parte communication.
16 You must go through the proper channels to communicate
17 with the Board, so the Board has not read that
18 document. It is pulled and it's in the process of
19 being shredded.

20 MS. SMITH: Good morning, Board. My
21 name is Marti Smith.

22 MEMBER GALASSI: Good morning.

23 MS. SMITH: I'm a registered nurse here
24 representing National Nurses United and University of

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1 Chicago Medical Center nurses, here to talk to you
2 today about Application No. 14-013.

3 University of Chicago Medical Center states
4 that they are an established provider of safety net
5 services with an enduring commitment to low-income and
6 other vulnerable populations. Unfortunately, that's
7 lip service.

8 University of Chicago Medicine actually only
9 provides 1.9 percent -- 1.69 percent of its net
10 revenue in charity care to the community while it
11 garners enormous tax breaks, of which I'm sure you're
12 all aware.

13 They have asked for this certificate of need
14 when, in fact, there is no need. They would like to
15 move medical/surgical beds to the new building because
16 it's very luxe, large private rooms that they can
17 attract more paying patients and international
18 patients with.

19 However, they cannot meet the regulatory
20 standard for having even as many medical/surgical beds
21 as they have. They can only justify 304 beds when
22 they currently have 338 licensed beds.

23 In addition, they cite the two-midnight rule
24 as a reason to justify 31 additional observation beds.

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1 Observation has been closed at University of Chicago
2 Medicine. I actually have a memo from the manager
3 dated on the same day that this application was
4 submitted that states that it's been closed and that
5 they're working to improve census, so they clearly
6 have no current need for these observation beds.

7 Meanwhile, there's a staffing crisis.

8 MR. ROATE: Two minutes have passed.

9 MS. SMITH: I'm sorry?

10 MR. ROATE: Two minutes.

11 CHAIRPERSON OLSON: Please conclude your
12 comments.

13 MS. SMITH: Okay. There's a staffing
14 crisis in the University of Chicago. These are
15 one-quarter of this year's staffing -- unsafe staffing
16 reports from nurses working. Our concern is that, if
17 you approve additional beds, they will continue to not
18 staff them.

19 And so we respectfully ask for you to deny
20 this request.

21 CHAIRPERSON OLSON: Thank you.

22 MS. MORRIS MOORE: Hi. My name is
23 Veronica Morris Moore.

24 I'm here to testify on behalf of the

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1 Trauma Care Coalition. We are a coalition of medical
2 professionals, community organizers, south side youth,
3 faith leaders, and University of Chicago students.

4 While the current proposal is not related to
5 the provision of trauma care, our institutional
6 knowledge of the UCMC and experience of working in its
7 surrounding communities enables us to offer available
8 commentary on this application.

9 In the letter attached to the application,
10 UCM President Sharon O'Keefe writes that the transfer
11 of beds is necessary to ensure that UCM is providing
12 medical care at a level matching industry standards
13 and to best match the use of their medical campus to
14 existing demand for health care within the community.

15 The application states that the transfer
16 would not increase the number of available
17 medical/surgery beds and, moreover, that Mitchell is
18 still sufficient for high-quality inpatient care.
19 Larger room sizes and more single-occupancy medical/
20 surgical rooms are low on the list of existing
21 community demands for health care, particularly when
22 compared with the current lack of availability of
23 trauma care. Patients suffering traumatic injuries in
24 many parts of UCM's core service area must be

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1 transported over 10 miles away to hospitals on the
2 north and west side of Oak Park.

3 The estimated cost for operating the adult
4 Level I trauma center is 25 million per year. The
5 proposed transfer of beds is estimated at 123 million.

6 The coalition respectfully asks that you
7 deny this request because it is another example of the
8 university's attempt to continue to pad their pockets
9 and ignore the needs of the community surrounding
10 them. These luxury beds would add -- would increase
11 the not-for-profit hospital's profits of \$156 million
12 already.

13 We feel as a community and as, also,
14 representing medical officials, that this is not a
15 necessity, this is not a need for the university, and
16 this is opportunity for the university to gain more
17 money. The University of Chicago has a responsibility
18 to its community. Whether it wants to honor that
19 responsibility or not --

20 MR. ROATE: Two minutes have passed.

21 MS. MORRIS MOORE: -- is not our job,
22 but we are here to ensure that they do honor the
23 neighborhood that they are existing in.

24 Thank you.

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1 CHAIRPERSON OLSON: Okay. Thank you.

2 MS. AVERY: Next for public
3 participation is Project No. 14-015, The Carle
4 Foundation, Phil Blankenburg, Nancy Greenwalt,
5 Russ Leigh, Jennifer Eardley, Dr. Jared Rogers, and
6 Dr. Tangelia.

7 MR. CONSTANTINO: Could you please print
8 your name on that yellow pad?

9 CHAIRPERSON OLSON: Good morning.
10 Are you Mr. Blankenburg?

11 MR. BLANKENBURG: I'm Phil Blankenburg.

12 CHAIRPERSON OLSON: Mr. Blankenburg.
13 Please, sir.

14 MR. BLANKENBURG: Good morning.

15 CHAIRPERSON OLSON: Good morning.

16 MEMBER GALASSI: Good morning.

17 MR. BLANKENBURG: My name is Phil
18 Blankenburg, and I am here today to express my full
19 support --

20 CHAIRPERSON OLSON: Can you pull that
21 just a little closer?

22 MR. BLANKENBURG: My name is Phil
23 Blankenburg, and I am here today to express my full
24 support for The Carle Foundation's certificate of need

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1 application to expand the number of beds at Carle
2 Hospital.

3 As a community representative on the board
4 of trustees for over 10 years, I've learned how
5 important Carle is to the region. Carle's reach goes
6 well beyond the immediate surrounding areas and
7 expands across east central Illinois and south nearly
8 to Kentucky.

9 One of the most impressive things about
10 Carle is the collaboration of hospitals and physicians
11 throughout the region. Carle has strong relationships
12 with critical access hospitals, including the Kirby
13 Hospital, which is the town in which I live,
14 Monticello, Illinois. Regional critical access
15 hospitals rely on open beds at Carle for those who
16 can't be treated locally, obviously.

17 When Carle -- while Carle fully supports the
18 need for keeping patients local, it is comforting for
19 our community and, indeed, the region that Carle
20 stands ready to offer advanced expert care -- and
21 I emphasize "advanced expert care" -- when it's
22 needed. The rural region depends on those resources
23 and the level of care available at Carle.

24 It allows patients to stay close to home,

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1 near their loved ones, while receiving top-quality
2 care one would expect only in a major metropolitan
3 area. It's vital that Carle have the capacity to
4 accept those patients when specialty services are
5 needed.

6 I urge the Health Facilities Planning Board
7 to approve Carle's expansion for the 48 additional
8 beds.

9 Thank you.

10 CHAIRPERSON OLSON: Thank you.

11 Next is . . . Nancy?

12 Is Jennifer at the table?

13 DR. EARDLEY: Here.

14 CHAIRPERSON OLSON: Oh, okay.

15 Jennifer's next.

16 DR. EARDLEY: Good morning. I'm
17 Jennifer Eardley, and I appear on behalf of the
18 University of Illinois at Urbana-Champaign.

19 I'm here in support of Project 14-015 for
20 The Carle Foundation Hospital. The university's
21 chancellor, Dr. Phyllis Wise, has expressed strong
22 support for this project but is unable to attend
23 today.

24 As associate vice chancellor for research

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1 and interim director of the division of biomedical
2 sciences at Illinois, I can attest to the importance
3 of this project to advance health care in our
4 community.

5 In my role at the university, I work
6 directly with Carle on a number of collaborative
7 medical research initiatives. University faculty and
8 students currently work with Carle physicians, staff,
9 and patients on work studies in areas such as urology,
10 oncology, cardiology, medical imaging, degenerative
11 medicine, and a number of other areas. These projects
12 hope to advance diagnostics, new treatments, and to
13 advance the delivery of health care.

14 Interaction with physicians and clinical
15 care providers and patients is critical to the success
16 of these projects, and focusing on -- having a focus
17 on subspecialty medicine growing at Carle is very
18 important for the future of these activities at the
19 university.

20 Carle already serves a large area. As you
21 just heard, the demand for advanced care treatment in
22 this region is expanding. Carle's ability to offer
23 advanced care will help expand opportunities for
24 University of Illinois researchers, first to better

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1 understand the health care needs of the state and to
2 focus innovative research initiatives on those needs.

3 Carle also currently serves as the primary
4 clinical teaching place for the University of
5 Illinois-Chicago regional college of medicine in
6 Urbana.

7 Carle partners with the college to provide
8 clinical training to students, to University of
9 Illinois internal medicine residents, to residents in
10 three Carle-sponsored residency programs, so expanding
11 access to care at Carle means more opportunities to
12 educate physicians of tomorrow, those who will serve
13 communities throughout the state.

14 Recently Carle and the University of
15 Illinois at Urbana-Champaign began to explore the
16 development of a new engineering basis --

17 MR. ROATE: Two minutes.

18 DR. EARDLEY: -- dedicated to advancing
19 health care through innovation and discovery at the
20 intersection of engineering and medicine.

21 We firmly believe that the expansion of
22 space at Carle will be critical to achieving these
23 goals, to providing more access to specialized care in
24 the region and improving the access to quality health

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1 care in our region, and we strongly support the
2 project.

3 Thank you for the opportunity to comment.

4 CHAIRPERSON OLSON: Thank you.

5 Nancy Greenwal t.

6 MS. GREENWALT: Good mornin g.

7 My name is Nancy Greenwal t, and I'm the
8 executive director of Promise Heal thcare, which
9 operates the Frances Nel son Heal th Center and
10 SmileHealthy dental program, a Federally qualified
11 health center in Champaign, Illinois.

12 I'm here in support of Carle Foundation
13 Hospital's proposed plan, No. 14-015, to increase
14 capacity to care for patients.

15 Frances Nel son is a primary medical and
16 mental health clinic, and SmileHealthy is a dental
17 clinic and mobile programs providing care to the
18 medically underserved in Champaign County.

19 Champaign County has 69,701 people living
20 below 200 percent of the Federal poverty level and the
21 third highest rate of extreme poverty in Illinois.
22 19,711 or 8.8 percent of those living in Champaign
23 County earn less than half the Federal poverty level,
24 and 15 percent of our residents are uninsured.

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1 Our patients are generally low-income and
2 either uninsured or covered by Medicaid. Many
3 patients have complex conditions which necessitate
4 specialty care, and our organization's been working to
5 improve access by partnering with providers and
6 hospitals, include Carle.

7 We've made great strides to improve access.
8 We've hired providers, adjusted schedules to see more
9 patients, raised funds, and added services. We refer
10 patients daily to Carle's specialists, including
11 neurosciences, oncology, heart and vascular
12 specialists, and others.

13 At Carle our patients receive the advanced
14 care they need while benefitting from a generous
15 charity care program extending to both physician care
16 and inpatient and outpatient hospital services.

17 We appreciate the strong support that Carle
18 Foundation Hospital has provided the work at Promise
19 Healthcare. In 2005 Carle helped move Frances Nelson
20 out of a cramped clinic in a small house by purchasing
21 and renovating a building to ensure that our friendly,
22 qualified health center had proper space.

23 More recently, Carle invested a hundred
24 thousand dollars as part of a community effort to

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1 build the SmileHealthy dental clinic and continues to
2 contribute financial, professional, and leadership
3 support to help create a true safety net for our
4 community.

5 Our patients cannot afford to travel 50 to
6 100 miles to another city for the complex care that
7 Carle provides, and our community cannot afford to see
8 this expansion delayed. Please approve The Carle
9 Foundation Hospital proposal before you today.

10 And thank you for your consideration.

11 CHAIRPERSON OLSON: Thank you.

12 MS. AVERY: Ross Leigh.

13 MR. LEIGH: I'm Ross Leigh from
14 Hoopston, Illinois. I appreciate this opportunity to
15 support the project proposed by Carle Foundation
16 Hospital that will improve access to health care for
17 the residents of my community and throughout central
18 Illinois.

19 As board chairman of Hoopston Regional
20 Health Center, we worked to ensure that health care
21 services would be available, especially because we
22 live an hour from the closest Level I trauma center,
23 which is Carle.

24 I can cite numerous examples of people in

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1 our areas whose lives were saved by Hoopeston Regional
2 Health Center and Carle. I joined the board of
3 directors of Hoopeston Regional Health Center more
4 than 30 years ago and have worked to ensure that
5 families, friends, and neighbors would continue to
6 have access to this care.

7 Over time the hospital in Hoopeston pursued
8 an affiliation with Carle because patients in northern
9 Vermilion County relied upon Carle's advanced
10 capabilities. Physicians and staff in Hoopeston were
11 able to adopt Carle's standards of care for conditions
12 like stroke, which allows the highest level of care to
13 begin while a patient is in Hoopeston.

14 Our close affiliation with Carle means we
15 don't have to send loved ones to Chicago or Indiana
16 for advanced treatment, and it saves families from the
17 added burden of lengthy travel. When patients need
18 follow-up care, they can consult with a specialist in
19 Hoopeston, and medical records are available
20 regardless of whether the patient was hospitalized in
21 Hoopeston or Urbana.

22 While we are a rural community, people in
23 Hoopeston still need access to highly specialized care
24 like that offered by Carle. The role of smaller

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1 community hospitals has shifted to providing for
2 inpatient services and serving as a medical home for
3 patients. As such, collaboration between small
4 community hospitals and a tertiary care facility with
5 highly specialized care has a dramatic positive effect
6 on access to high-quality health care services and
7 continuity of care.

8 This proposal is important for the residents
9 of east central Illinois communities as this shift
10 creates additional demand. And if Carle must divert
11 these patients, it means more time to obtain treatment
12 and a higher potential for a bad outcome for people
13 living in rural communities.

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

17 Thank you very much.

18 CHAIRPERSON OLSON: Thank you, sir.

19 Dr. Jared Rogers.

20 DR. ROGERS: Good morning. I'm
21 Dr. Jared Rogers. I'm interim CEO and president of
22 Presence Health's central Illinois region. I'm also a
23 family doctor and was in private practice for many
24 years, including Mendota for many years.

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1 I'd like to speak in opposition to Carle's
2 proposal, making two main points.

3 The first main point is Carle's
4 unwillingness to collaborate on numerous projects in
5 the recent past, to include those neonatal services,
6 neonatal intensive care services. Another example
7 would be ambulatory surgery services in our Danville
8 community, where we both have underutilized surgery
9 centers.

10 A third example would be, after Carle made
11 the request for this CON, that we scheduled, for
12 Presence Health, a phone call conference with them to
13 discuss collaboration in medical/surgical care. They
14 did send a representative to this phone call, but her
15 purpose seemed to be trying to justify why they needed
16 the excess medical/surgical capacity. But she did say
17 that Carle would help us repurpose our hospital,
18 Presence Covenant, to a behavioral health facility
19 after we no longer needed our medical/surgical beds.

20 This was reiterated in a letter that we
21 received a few days later by our CEO of Presence
22 Health from Carle's CEO about the repurposing of our
23 hospital, as well as offering to purchase our hospital
24 in Danville.

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1 The second main point I would like to make
2 is, where are the physician letters of support for
3 this expansion and explain where the patients would
4 come from?

5 They don't exist because they would have to
6 say that the patients would need to come from other
7 area hospitals. There is really no expansion of any
8 significant new medical service by Carle, and there's
9 certainly no appreciable population growth.

10 Certainly, this Board does not have the
11 responsibility to protect the market share of other
12 hospitals, but I know the Board has high priorities in
13 preventing duplication of services, expanding the
14 excess beds in our region, which are currently at
15 158 -- this would put them well over 200 -- and, also,
16 limiting the growth of health care costs in our
17 region.

18 So I would ask that you deny this request
19 and relieve the burden of the community members on
20 paying for this expansion.

21 MR. ROATE: Two minutes.

22 DR. ROGERS: Thank you.

23 CHAIRPERSON OLSON: Thank you, Doctor.

24 Dr. Tangel la.

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1 DR. TANGELLA: Good morning.

2 My name is Krishna Tangella. I'm a board-
3 certified pathologist. I'm the regional medical
4 director for laboratory services at Provena
5 Covenant -- or Presence Covenant Medical Center in
6 Urbana and in Danville.

7 As a physician in the community who has
8 practiced for a long time, I cannot emphasize to you
9 enough how important it is for our patients in our
10 community to have two vibrant hospitals. Our choice
11 of hospitals are more -- most often directed by
12 patients' choice and preference, their choice as
13 individuals, and that's how it should be. We have
14 found little difference in clinical capabilities of
15 the two hospitals.

16 I fear for the future of Covenant. Simply
17 stated, I doubt the ability to maintain our
18 programmatic commitment to the residents of the
19 central Illinois region should our current patients be
20 shifted to another facility.

21 As I look at our community and all of east
22 central Illinois, for that matter, I do not see any
23 substantial population growth. This leads me to
24 conclude that patients that Carle is counting on to

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1 fill its additional 48 beds would come from other
2 hospitals in the region, primarily from Covenant,
3 which is located just two minutes down the street.

4 When considering Carle's desire to expand
5 another 48 med/surg beds, I urge you to take into
6 consideration the impact this is going to have on
7 Covenant and the community that we live in.

8 There is no absence of access to care in
9 Urbana. Covenant is located just two minutes away
10 from Carle. The region has identified 158 excess beds
11 currently. There are beds available at Presence
12 Covenant Medical Center, Presence United Medical
13 Center, Gibson Area Hospital, Sarah Bush Lincoln
14 Hospital, and Carle's own Hoopeston Hospital. There
15 has to be a better solution.

16 I, therefore, urge sincerely and humbly
17 to deny Carle's application for additional 48 med/surg
18 beds.

19 CHAIRPERSON OLSON: Thank you, Doctor.

20 You may be excused.

21 MS. AVERY: Okay. Continuing with
22 Project No. 14-015, The Carle Foundation Hospital, we
23 have Dr. Tuchek, Dr. Carmen Rocco, Becky Von Holten,
24 Mayor Prussing, Tabrina Davis, and Christina Nelson.

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1 You can start.

2 You can start.

3 DR. TUCHEK: Oh, I can start?

4 CHAIRPERSON OLSON: Are you Dr. Tuchek?

5 Please go ahead, sir.

6 DR. TUCHEK: Chairman Olson, Board
7 members, my name is Dr. Michael Tuchek. I'm a
8 professor of cardiac surgery at Loyola University here
9 in Chicago and a senior partner in Cardiac Surgery
10 Associates, the biggest group of heart surgeons in the
11 country. We do about a quarter of all the open-hearts
12 in the state of Illinois, about 4,000 open-hearts a
13 year. We do heart transplants, lung transplants,
14 multiple trials with percutaneous valves and assistive
15 devices. You name it, we do it.

16 There's a plethora of specialists at both
17 hospitals in Urbana, but I'm here to dispel a myth.
18 The myth is that Carle Foundation Hospital is the only
19 real tertiary care center provided in the region.
20 Simply not true. The clinical capabilities at Carle
21 are hardly unique to Carle. That's good marketing,
22 perhaps, but from a medical perspective, it simply
23 isn't true.

24 Dr. Singh in our group provides the same

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1 cardiovascular surgical services routinely at Covenant
2 as are provided at Carle with the rare exception, and
3 we have experience that far surpasses Carle, as I've
4 described above. Covenant is hardly a behavior health
5 center wannabe, as Carle has suggested.

6 Needless to say, this is a certificate of
7 need Board, not a certificate of want Board. We all
8 want, frankly, what's best for our patients, and
9 adding 48 med/surg beds at Carle Clinic simply will
10 not accomplish that.

11 On the contrary, siphoning off patients from
12 other area hospitals will only serve to cripple those
13 institutions to the detriment of the area residents.
14 Giving Carle even more medical/surgical beds not only
15 removes patients of services; it takes away from the
16 actual need in the area, which includes more primary
17 care, additional outpatient clinics to make Carle more
18 accessible, and more preventive medicine for other
19 things.

20 As a heart surgeon whose group provides
21 state-of-the-art, university-level tertiary care
22 services at Covenant in the area, I can unequivocally
23 say that there's no need to increase beds at Carle
24 when Covenant, which is right down the street, has the

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1 staff, the resources, and capacity to do so.

2 Thus, I strongly urge you to deny Carle's
3 application on behalf of my patients, as Carle's
4 argument is hollow and fails to show any real need,
5 which is the fundamental reason we have a CON Board
6 here in Illinois. Carle's argument fails your litmus
7 test hands down.

8 Thank you.

9 CHAIRPERSON OLSON: Thank you, Doctor.
10 Dr. Rocco.

11 DR. ROCCO: Good morning. My name is
12 Dr. Carmen Rocco. I'm the chief medical officer at
13 Presence United Samaritans Medical Center in Danville.

14 I am here to discuss the effect this
15 proposal would have on our hospital and our community.
16 As a physician, I am concerned that Carle seems to be
17 more interested in shifting patients and physicians
18 out of local communities like Danville and into
19 parallel facilities instead of coordinating with local
20 physicians to provide care at nearby facilities.

21 In fact, Carle has already shifted its
22 primary care providers and general surgeons from
23 hospitals in our area to its own facilities, diverting
24 patients away from the community. At Presence United

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1 Samari tans, we have already lost physicians from
2 general surgery, cardi ology, and fami ly medi cine as
3 Carle has pulled their physicians from communi ty
4 hospi tal s.

5 What this means is we now have a lack of
6 on-call coverage for certain special ties at our
7 hospi tal s in Danville. Without these special ties on
8 call, more patients are forced to leave Danville for
9 care that could otherwise easi ly be provided at
10 Presence United Samari tans. We are losing good,
11 long-term physicians who are an asset to our communi ty
12 to this business practice of Carle's. It also thwarts
13 our ability at Presence United Samari tans to develop
14 new services for the Danville communi ty.

15 I believe it is not in the best interests of
16 our patients to force them to travel outside the
17 communi ty for care because of one health care enti ty's
18 desire to take over hospi tal s, physi ci an practices,
19 and other options in the region. Patients deserve
20 choice and they deserve to be treated closer to home.
21 This project takes away choices and funnel s patients
22 out of Danville and other local towns.

23 I respectfully urge the Board to deny this
24 appli ca ti on.

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1 Thank you.

2 CHAIRPERSON OLSON: Thank you, Doctor.
3 Becky Van Hol ten.

4 (No response.)

5 CHAIRPERSON OLSON: Becky's not here?

6 (No response.)

7 CHAIRPERSON OLSON: Mayor Laura Prussing.

8 MS. PRUSSING: Good morning. I'm Mayor
9 Laurel Prussing of Urbana, Illinois, which is home to
10 two regional hospitals, Carle and Presence.

11 Carle is twice as big as Presence. Carle
12 serves a region of 1.2 million people in 25 counties
13 in Illinois and Indiana. And as mayor of Urbana, I'm
14 concerned that this project is not in the public
15 interest.

16 Carle has publicly stated that health
17 insurance costs more in Urbana than in Chicago. Why?
18 Most other prices are lower than in Urbana, but
19 Chicago hospitals face competition while Carle has a
20 near monopoly. Carle has a captive insurance company,
21 which it protects by not allowing many of its
22 physicians to be available through other health
23 insurance.

24 The City of Urbana has been paying over

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1 \$2 million a year for our employees to be insured, and
2 I think this price gouging has cost us millions of
3 dollars over the years and the University of Illinois,
4 State of Illinois, many millions of dollars that
5 didn't need to be spent.

6 This project would tighten Carle's grip even
7 more by undermining its local competitor, Presence.
8 Carle has \$17 million in cash for this project, a
9 testimony to its near monopoly. Also, for the time
10 being, at least, it has evaded a 2010 Illinois Supreme
11 Court decision by getting a controversial law passed
12 in 2012 exempting itself from property taxes.
13 Hospitals no longer have to pay property taxes if
14 their charity care exceeds the property tax.

15 The city of Urbana, 41,250 people, has
16 87 percent of Carle's property. That means that we
17 are paying the charity care for 1.2 million people in
18 truth.

19 This law cut Urbana's assessed value
20 11 percent, shifting Carle's taxes to all other Urbana
21 businesses and residents. Not only is this unfair,
22 but it puts Urbana on an unsustainable path by
23 significantly raising our tax rate above our next-door
24 neighbor, the city of Champaign.

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1 Even when --

2 MR. ROATE: Two minutes.

3 MS. PRUSSING: I'm almost finished.

4 Even when Carle paid property taxes, its net
5 income was over \$100 million a year, more than twice
6 the total budget of the City. Carle's taxes to Urbana
7 were about a million dollars a year while we were
8 paying health insurance of \$2 million.

9 I'm glad this Board has concluded the
10 project is not needed. I hope you have also
11 considered that this project would add to Carle's
12 undue market power and harm the public with even
13 higher health care costs.

14 Thank you very much.

15 CHAIRPERSON OLSON: Thank you, Mayor.
16 Tabrina Davis.

17 MS. DAVIS: Good morning. My name is
18 Tabrina Davis. I am here to provide testimony on
19 behalf of Sandra Bruce, our president and CEO of
20 Presence Health.

21 Presence Health believes that The Carle
22 Foundation proposal to add 48 medical/surgical beds
23 should be issued an intent to deny. The State's
24 designated service area is already clearly overbedded

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1 by 158 beds. As you are aware, there is no issue of a
2 lack of access to services in our planning area.

3 The question we must ask is, where is Carle
4 going to get the 2600 to 2700 additional admissions
5 that it's projecting in 2016? The only conclusion
6 that can be drawn is that they're going to come from
7 the other area hospitals.

8 It is important to note that Carle
9 disregarded the review criteria requiring that
10 physician referral letters be provided to justify the
11 additional beds. Those letters must include where the
12 physicians are currently admitting patients and are
13 required for projects such as that proposed expansion
14 of existing services.

15 The impact of Carle's expansion will be
16 devastating to the other area hospitals and most
17 certainly to Presence Covenant, which is located only
18 two minutes away. Presence Covenant is approved to
19 operate 110 beds, service beds, and today maintains an
20 average daily census of less than half capacity with
21 44 patients. Letters of opposition have been filed by
22 three area hospitals.

23 Presence has approved Carle -- has
24 approached Carle a number of times in recent years,

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1 suggesting that we collaborate on a number of programs
2 that would benefit our patients, with little success.
3 Rather, Carle has countered with a proposal to buy our
4 Danville hospital and to address any excess bed
5 capacity at our Urbana hospital by converting it to a
6 psychiatric facility.

7 Carle's strategy of growth at the expense of
8 its neighboring hospitals is clear. With its
9 physicians located outside of Urbana shifting their
10 admissions from the local hospitals in places like
11 Danville and Mason City to their Urbana flagship, this
12 strategy of growth threatens the commitment of the
13 other hospitals to serve their communities.

14 The addition of 48 beds -- service beds --
15 will do nothing for UI research. Again, this threat
16 is no greater on any hospital --

17 MR. ROATE: Two minutes.

18 MS. DAVIS: -- than Presence Covenant,
19 located two minutes away with an average of
20 66 med/surg beds unoccupied every day.

21 We urge you to deny this application and
22 thank you for listening to our concerns.

23 CHAIRPERSON OLSON: Thank you.

24 And you must be Christina Nelson.

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1 MS. NELSON: Yes, by process of
2 elimination.

3 Can you hear me?

4 Can you hear me?

5 CHAIRPERSON OLSON: Can you hear her?

6 MS. NELSON: Can everybody hear? Okay.

7 "Power tends to corrupt. Absolute power
8 corrupts absolutely." Those words are even truer
9 today than they were in the late 19th century when
10 they were written, especially when it pertains to
11 Carle's expansion.

12 Carle is -- seems to be, with this proposal,
13 trying to tighten the noose on their competition. If
14 you approve the application before you, you are
15 one step closer to giving Carle the complete control
16 they want and the stronghold on health care we in the
17 area dread.

18 According to a recent editorial in the
19 New York Times, health care costs in Boston increased
20 after the merger of Mass General and Brigham and
21 Women's, and insurance companies were less able to
22 negotiate better rates for coverage.

23 Given Carle's recent -- I can't read my own
24 notes.

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1 Giving Carle more power might well influence
2 the choice of insurance companies with whom they're
3 willing to deal. Anyone with Blue Cross, for example,
4 has always had problems with Carle. The clinic
5 specialists, as well as the hospital, now are
6 Blue Cross PPO providers, but internal medicine,
7 family medicine, and the convenient care physicians at
8 Carle are not in any Blue Cross network.

9 As a former iCHIP patient -- Blue Cross was
10 the administrator -- unknowingly I was knowingly and
11 unashamedly exploited by Carle for years. If given
12 further power in our community, they will have no
13 incentive to try to work with a variety of insurers.

14 They've already started to increase their
15 costs. They've implemented a \$200 facility fee for
16 each visit, and a friend of mine, who was forced to
17 convenient care because she couldn't get an
18 appointment with her doctor, was forced to pay \$400
19 out of pocket.

20 In the application under consideration,
21 Carle says the project will cost \$17,765,000. If
22 they're willing to spend that amount in cash and
23 securities on a project that does not, in your staff's
24 opinion, meet the criterion of need --

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1 MR. ROATE: Two minutes.

2 MS. NELSON: I just have a couple more
3 things.

4 -- why are they so insistent they won't
5 contribute to the City of Urbana? Their tax-exempt
6 status was revoked for a reason.

7 I now pay an increased property tax because
8 they pay no tax at all. My property tax bill went up
9 by 10 percent, and my fellow homeowners pay for
10 Carle's fire and police protection right now because
11 they don't make property tax payments or pay other
12 tax. They're an institutional bully and they
13 should -- we should have a compassionate alternative
14 in our community, especially one that's so sensitive
15 to Medicaid patients.

16 I brought a copy of what I wrote out, plus,
17 since we didn't know until the last minute that this
18 meeting was happening, several other people in the
19 Concerned Citizens of Urbana group -- of which I'm a
20 member -- have sent in sort of Hail Mary letters in
21 hopes that you will read them.

22 CHAIRPERSON OLSON: Actually, we -- we
23 can't take that.

24 MEMBER GALASSI: We can't accept those.

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1 MS. NELSON: You can't?

2 CHAIRPERSON OLSON: No. We can't accept
3 those --

4 MS. NELSON: Oh, okay.

5 CHAIRPERSON OLSON: -- for the same
6 reason that we couldn't accept that other.

7 Thank you for your comments.

8 You may be dismissed. Thank you.

9 MS. AVERY: Next up for public
10 participation is Project No. 14-020, Chicago Ridge
11 Dialysis, Mary Werner and Michael Arvan.

12 You can start.

13 CHAIRPERSON OLSON: Mary, you can go
14 ahead.

15 MS. WERNER: Thank you.

16 Good morning. I am Mary Werner, the Village
17 president of Worth, and I am here to support DaVi ta's
18 proposal to establish a 16-station dialysis facility
19 in Chicago Ridge, Illinois.

20 This project is very important to me not
21 only professionally but personally. Currently there
22 are 67 dialysis patients residing within five minutes
23 of this proposed facility. There is no dialysis
24 facility in Chicago Ridge or in Worth, and the closest

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1 facility is at least 10 minutes away, and it's very
2 highly utilized.

3 The proposed Chicago Ridge facility will
4 improve access to dialysis for residents of Chicago
5 Ridge and Worth, and literally within a couple hundred
6 yards is the village of Palos Hills and Bridgeview.
7 I understand how important having a dialysis facility
8 close to home is to patients, as I recently lost a
9 neighbor who lived across the street from me that
10 suffered from end stage renal disease.

11 Dialysis is stressful for patients and their
12 friends and their families. Not only do patients
13 spend up to 15 hours per week dialyzing in an
14 in-center facility, but they often miss important
15 family events because of their treatment.

16 Additionally, there are many difficult side
17 effects associated with dialysis. Typically when
18 I would see my neighbor and ask her how her husband
19 was, she would simply reply "He's just okay" or "Today
20 is not a good day."

21 Further, many patients on dialysis are
22 elderly, and they require transportation assistance.
23 This past winter was a great example of how important
24 it is to have a facility close to home. It was so

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1 extremely cold, and you may recall it just kept
2 snowing and snowing and snowing.

3 When a dialysis facility is not proximately
4 located to the patient's residence, it is more
5 difficult to arrange transportation to and from these
6 points.

7 MR. ROATE: Two minutes.

8 MS. WERNER: DaVita's proposed Chicago
9 Ridge facility will benefit the residents from my
10 community who suffer from ESRD. Not only will it
11 provide traditional in-center hemodialysis, but
12 I understand DaVita will also provide home
13 hemodialysis and PD training.

14 I strongly support DaVita's proposal to
15 establish in the village of Chicago Ridge and
16 thank you for your time today.

17 CHAIRPERSON OLSON: Thank you.

18 Doctor.

19 DR. ARVAN: Good morning. My name is
20 Dr. Michael Arvan, a practicing nephrologist serving
21 Chicago Ridge and adjoining areas.

22 With my partner, Dr. Sreya Pallath, we are
23 joint-venturing with DaVita in this proposed
24 establishment of the facility in Chicago Ridge.

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1 I'm here to voice my support for this facility.

2 As will be detailed later by my partner
3 Dr. Pallath in the presentation, our practice is
4 experiencing a tremendous growth parallel to the
5 epidemic of chronic kidney disease facing the nation.
6 We are estimating, within our three-person group, just
7 over 1,000 patients who qualify for either Stage 3,
8 Stage 4, or Stage 5 chronic kidney disease, and we've
9 experienced nearly 300 new patients just since the
10 initial filing for this certification recently. This
11 represents a 30 percent increase since the initial
12 filing.

13 While I understand there's another project
14 before the Board today in the same general planning
15 area of Chicago Ridge, I believe strongly that there's
16 a sufficient patient population to justify both
17 locations.

18 First, in preparation for today's testimony,
19 within our group we were able to identify about
20 179 patients who qualify for pre-end stage renal
21 disease of either Stage 4 or Stage 5, and they live
22 within 30 minutes of this facility.

23 We feel that only 77 patients would be
24 required to justify the establishment of a 16-unit

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1 facility here as we -- and we have been able to have
2 patients -- about 4 patients per month have been
3 transitioning to hemodialysis every month.

4 Second, Fresenius -- the Fresenius unit in
5 Summit and this unit in Chicago Ridge will be serving
6 two different, distinctive patient populations. The
7 Chicago Ridge unit is to the southeast and would be
8 covering mostly Chicago Ridge, Worth, Oak Lawn, and
9 Evergreen Park, whereas the Fresenius Summit unit
10 would be taking patients mostly from Summit, Worth,
11 Bedford Park, and Lyons. There is some overlap in
12 Burbank, but we feel this would be marginal.

13 Finally, we are very proud of our commitment
14 with DaVita to promoting home dialysis techniques to
15 patients who are capable and agreeable. Again,
16 including peritoneal dialysis and home hemodialysis,
17 we find this to be very exciting, and we'd love to be
18 able to offer a convenient location of training for
19 these patients that are interested.

20 MR. ROATE: Two minutes.

21 DR. ARVAN: Thank you for your time, and
22 we would strongly urge your approval of this proposal.

23 CHAIRPERSON OLSON: Thank you, Doctor.

24 That concludes the public participation

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OPEN SESSION**

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1 portion of the agenda today.

2 We're just going to do the approval of the
3 postpermits approved by the Chairperson, and then
4 we're going to take a 10-minute break.

5 Mr. Constantino.

6 MR. CONSTANTINO: Thank you, Madam
7 Chair man.

8 The Chairman has approved the following:
9 A permit alteration for Permit No. 13-067, Luther
10 Oaks; a permit renewal for Permit No. 12-029,
11 BMA Southwestern Illinois; finally, a permit
12 alteration for Permit No. 09-030, Addison Rehab and
13 Living Center in Elgin.

14 Thank you, Madam Chair man.

15 CHAIRPERSON OLSON: May I have a motion
16 to approve those three?

17 MEMBER GALASSI: So moved.

18 VICE CHAIRMAN HAYES: Second.

19 MEMBER BRADLEY: Second.

20 CHAIRPERSON OLSON: I'm sorry. I don't
21 need to do that. I guess they've been approved, so
22 this is informational.

23 I'm sorry. Okay. Unless there are any
24 questions. Any questions from anyone?

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1 MEMBER GALASSI: No, ma'am.

2 CHAIRPERSON OLSON: Okay. It is 10:22.

3 We'll reconvene at 10:35.

4 (Recess taken, 10:22 a.m. to
5 10:35 a.m.)

6 CHAIRPERSON OLSON: Let's call the
7 meeting back to order.

8 The next item for State Board action is
9 permit renewal requests.

10 12-084, PCC Community Wellness Center,
11 birthing center, in Berwyn is requesting a four-month
12 renewal to August 5th of -- from August 5th of 2014 to
13 December 31st of 2014.

14 May I have a motion to approve
15 Project 12-084?

16 VICE CHAIRMAN HAYES: So moved.

17 MEMBER GREIMAN: Second.

18 CHAIRPERSON OLSON: It has been moved
19 and seconded to approve Project 12-084.

20 May I have the State -- oh, I'm sorry.

21 The Applicant can come to the table.

22 I'm sorry. Sorry, Bob.

23 MR. ROBERT URSO: That's all right.

24 CHAIRPERSON OLSON: We switched up our

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PCC COMMUNITY WELLNESS CENTER**

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1 order in order to more closely follow Robert's Rules,
2 so if some of you are confused about why we're doing
3 it this way, that's why, because Robert's Rules says
4 we get the motion, second the motion, and then ask --
5 so may I have the State Board staff report,
6 Mr. Constantino.

7 MR. CONSTANTINO: Thank you,
8 Madam Chairwoman.

9 The State Board approved this project in
10 February of 2013 for a freestanding birthing center as
11 part of a demonstration program under the Alternative
12 Health Care Delivery Act.

13 They're here before you today wanting to
14 renew their permit until December 31st, 2014. The
15 approximate cost of the project is \$450,000.

16 This is the second permit renewal request.
17 There was no opposition. And the State Board staff
18 finds the Applicant in compliance with all the permit
19 renewal requirements.

20 Thank you, Madam Chairwoman.

21 CHAIRPERSON OLSON: Since there is no
22 opposition and no findings, would you just answer
23 questions, or do you have a presentation?

24 MR. ROBERT URSO: I can just answer

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PCC COMMUNITY WELLNESS CENTER**

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1 questions.

2 CHAIRPERSON OLSON: Questions or
3 comments from the Board?

4 MEMBER GALASSI: None.

5 CHAIRPERSON OLSON: Seeing no -- seeing
6 no further questions or comments --

7 MEMBER SEWELL: Madam Chair --

8 CHAIRPERSON OLSON: Oh, I'm sorry.

9 MEMBER SEWELL: -- I just want to make a
10 statement to the Board.

11 I don't think I need to abstain on this due
12 to conflict, but I'm a member of the board of Health &
13 Medicine Policy Research Group, and they have
14 advocated for freestanding birth centers for almost
15 30 years.

16 So I just think the Board should know that
17 for the record.

18 CHAIRPERSON OLSON: Thank you,
19 Mr. Sewell.

20 Roll call vote, please.

21 MR. ROATE: Motion made by Mr. Hayes;
22 seconded by Justice Greiman.

23 Mr. Bradley.

24 MEMBER BRADLEY: Yes.

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1 MR. ROATE: Justice Greiman.
2 MEMBER GREIMAN: Yes.
3 MR. ROATE: Mr. Galassi.
4 MEMBER GALASSI: Yes.
5 MR. ROATE: Mr. Hayes.
6 VICE CHAIRMAN HAYES: Yes.
7 MR. ROATE: Mr. Sewell.
8 MEMBER SEWELL: Yes.
9 MR. ROATE: Chairwoman Olson.
10 CHAIRPERSON OLSON: Yes.
11 MR. ROATE: That's 6 votes in the
12 affirmative.
13 CHAIRPERSON OLSON: Motion passes.
14 MR. ROBERT URSO: Thank you.
15 CHAIRPERSON OLSON: Thank you.
16 MEMBER GALASSI: Congratulations.
17 CHAIRPERSON OLSON: Good luck.
18 The next order of business is extension
19 requests. There are none.
20 The next order of business is exemption
21 requests.
22 This is the Northwestern/Cadence project.
23 Would the Applicant please come to the table.
24 While they're doing that, may I have a

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1 motion to approve Projects -- we're going to take this
2 as one motion; right?

3 Is that . . . Project E-0014, Central DuPage
4 Hospital, Chicago, for a change of ownership;
5 Project 012-14, Delnor-Community Hospital, Geneva, for
6 a change of ownership; Project 013-14, CDH Proton
7 Center, Warrenville, for a change of ownership;
8 Project 014-14, Cadence Surgery Center, Warrenville,
9 for a change of ownership; Project 015-14, Tri-Cities
10 Surgery Center, Geneva, for a change of ownership.

11 And just to note, there's no opposition and
12 no findings to this project.

13 May I have a motion?

14 MEMBER BRADLEY: I so move.

15 MEMBER GALASSI: Second.

16 CHAIRPERSON OLSON: The motion has been
17 moved and seconded.

18 Mike, may we have the State Board staff
19 report.

20 MR. CONSTANTINO: Thank you,
21 Madam Chairwoman.

22 The Applicants, Northwestern Memorial
23 HealthCare and CDH-Delnor Health System, doing
24 business as Cadence Health, are proposing a change of

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1 ownership of Cadence Health to Northwestern Memorial
2 HealthCare. Northwestern Memorial HealthCare will
3 become the sole corporate member of Cadence Health.

4 There were no findings, no opposition to
5 this project, no opposition letters. The Applicants
6 have met all the requirements of the exemption.

7 Thank you, Madam Chairwoman.

8 CHAIRPERSON OLSON: And just to
9 clarify -- I'm going to ask Frank to clarify something
10 on the application before we proceed.

11 Frank.

12 MR. URSO: Thank you, Madam Chair.

13 As you're aware, the Attorney General did
14 take a look at this project. And we do have a
15 no-opposition letter from them, but they did have a --
16 a condition, so to speak, on their no-position paper
17 on this.

18 And so, you know, that -- they wanted you to
19 amend your bylaws of the Cadence Health Foundation to
20 add a new provision which will state as follows: "Any
21 unrestricted gifts that are held by the corporation as
22 of the effective date of the affiliation between
23 CDH-Delnor Health System, doing business as Cadence
24 Health, and Northwestern Memorial HealthCare will

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1 continue to be used in a manner consistent with the
2 corporation's charitable purposes for the benefit of
3 the institutions served by Cadence Health and/or the
4 populations located within Cadence Health's service
5 area."

6 And what they also requested is that they
7 would like you to amend your bylaws by the
8 transaction's closing date. And according to our
9 documentation, I believe that's September 1st of 2014.

10 So are you in agreement with that condition
11 to be placed on this exemption as well as the
12 time frame?

13 MS. ARDELL: We are.

14 MR. URSO: Okay. Thank you.

15 CHAIRPERSON OLSON: Does that require us
16 to amend the motion?

17 MR. URSO: Yes. Yes.

18 CHAIRPERSON OLSON: Oh, actually, we
19 need to swear them in before they tell us that -- not
20 that we don't believe you -- so we're all copacetic.

21 THE COURT REPORTER: Would you each
22 raise your right hands, please.

23 (Three witnesses duly sworn.)

24 THE COURT REPORTER: Thank you. And

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1 please print your names on the sheet.

2 And will you tell me your name, ma'am, who
3 spoke.

4 MS. ARDELL: Nancy Ardell.

5 THE COURT REPORTER: Thank you.

6 CHAIRPERSON OLSON: And we will ask the
7 question again if you are in agreement to change your
8 bylaws in accordance with the requirements of the
9 Attorney General's office.

10 MS. ARDELL: We are.

11 CHAIRPERSON OLSON: Thank you.

12 MR. URSO: Thank you.

13 CHAIRPERSON OLSON: There is no
14 opposition and no findings on this application.
15 You're more than welcome to give a presentation, if
16 you would like, or we'll open it to the Board for
17 questions.

18 MR. HARRISON: Questions.

19 CHAIRPERSON OLSON: Thank you.

20 Questions from the Board?

21 MEMBER GALASSI: Does the name Cadence
22 then go away?

23 MR. HARRISON: Yes. We'll market it as
24 Northwestern Hospitals.

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1 MEMBER GALASSI: Thank you.

2 CHAIRPERSON OLSON: Others?

3 VICE CHAIRMAN HAYES: Madam Chairman.

4 CHAIRPERSON OLSON: John.

5 VICE CHAIRMAN HAYES: I guess in
6 your . . . in your appraisal report you have a value
7 between 2.7 and \$3 billion; is that correct?

8 MR. HARRISON: Yes.

9 VICE CHAIRMAN HAYES: Okay. That is --
10 do you believe that the value of this -- of
11 Cadence Health is that, at that level?

12 Do you have any comments on -- because that
13 is very high, as I look at it but -- do you believe
14 that -- and you provided to your appraisal firm
15 projected operating results, which they used, then, to
16 be able to -- you know -- to be able to do their
17 analysis.

18 MR. HARRISON: We did. And I believe
19 we've also --

20 CHAIRPERSON OLSON: Can you --

21 MS. AVERY: Can you speak up into the --

22 MR. HARRISON: Is this on?

23 THE COURT REPORTER: State your name, if
24 you would, please.

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1 MR. HARRISON: I'm Dean Harrison.

2 I'm the president and CEO of Northwestern Memorial
3 HealthCare.

4 And one of the things that we have actually
5 provided for --

6 MR. URSO: Could you speak up, please?

7 CHAIRPERSON OLSON: I don't think
8 that's on.

9 MS. AVERY: It's not on.

10 MR. HARRISON: Let's try another one.

11 Okay. Thank you.

12 I'm Dean Harrison. I'm president and CEO of
13 Northwestern Memorial HealthCare.

14 And so the valuation was provided based upon
15 the information that we did provide the appraisers,
16 and our intent is to establish a designated fund that
17 is the net assets of Cadence Health to be reinvested
18 and continued to be invested in the communities served
19 by Cadence Health, so they're the beneficiaries.

20 MR. VIVODA: Does this one work?

21 MS. AVERY: We're working on it.

22 MR. VIVODA: Is that better?

23 CHAIRPERSON OLSON: Oh, there we go.

24 MR. URSO: There you go.

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1 MR. VIVODA: It works. We have to turn
2 it on. That's all. Sorry.

3 I'm Mike Vivoda. I'm the president and CEO
4 of Cadence Health today.

5 So the fair market value was done in
6 accordance with the requirements. Dean's comments
7 about the designated fund is the net cash available
8 now, not the net assets of the enterprise.

9 And as a combination of the two not-for-
10 profits, the fair market value is almost irrelevant in
11 the transaction. So it was provided, we did work with
12 an outside appraisal company, but we don't think it
13 impacts the combination of two not-for-profits.

14 MR. HARRISON: And what we meant by --
15 and it will be appropriately reflected in our audit
16 for next year by our auditors.

17 VICE CHAIRMAN HAYES: Now, you have --
18 the facilities themselves, are they a separate entity?
19 And who controls the -- that, the entities -- the
20 separate -- the facilities themselves, the hospitals?
21 And -- are they in another entity which is separate
22 from the operating entity of the hospitals?

23 MR. HARRISON: Northwestern Memorial
24 HealthCare will become the single parent for the

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1 hospital entities.

2 MS. ARDELL: Yes.

3 VICE CHAIRMAN HAYES: As well as the
4 physical assets and physical plant? There won't be
5 any leasing costs associated with that?

6 MR. HARRISON: No.

7 MR. URSO: You're going to have to speak
8 audibly so the court reporter can pick that up.

9 MS. ARDELL: No. Sorry.

10 Right. They will all be part of the same
11 corporation.

12 VICE CHAIRMAN HAYES: Okay. This says
13 here that the CDH and Delnor Health System, doing
14 business as Cadence Health, will remain this -- the
15 owner of the site.

16 MS. ARDELL: Right. The Cadence --
17 CDH and Delnor hospitals are part of Cadence, that's
18 right.

19 VICE CHAIRMAN HAYES: And they will --
20 the sole corporate parent, then, of Cadence Health
21 will be Northwestern?

22 MR. HARRISON: Right.

23 MS. ARDELL: Right.

24 VICE CHAIRMAN HAYES: Thank you.

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1 MS. ARDELL: Thank you.

2 CHAIRPERSON OLSON: Any other questions
3 or comments?

4 (No response.)

5 CHAIRPERSON OLSON: Just for the
6 record -- David.

7 MEMBER CARVALHO: Just a quick one.
8 When -- back when the proton center was
9 before the Board, there was also another proton center
10 before the Board, and that one was sponsored by
11 Northern Illinois University, and at the time I think
12 there were several Board members who were
13 particularly -- found that one particularly attractive
14 because of that nexus to a university and to a medical
15 component.

16 And so now, through an interesting turn of
17 events, now this proton center is also going to be
18 more tethered to an organization with that strong
19 nexus to a university.

20 Have there been any considerations about how
21 the use and nature of the proton center might change
22 because of that new nexus?

23 MR. HARRISON: So I'll just start off,
24 and then Mike can make a comment, as well.

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1 We couldn't be more excited to have the
2 opportunity for our faculty to participate in the
3 proton center. And so we see that as one of the real
4 valuable parts of our relationship, is to be able to
5 have our radiation oncologists and other faculty
6 members participate in that center itself.

7 MR. VIVODA: I have nothing to add.

8 CHAIRPERSON OLSON: Okay. Just for the
9 record, I'm going to repeat the motion, and then we'll
10 have a roll call vote.

11 The motion on the board is to approve
12 Projects -- for a change of ownership -- 008-14,
13 012-14, 013-14, 014-14, 015-14. And as a condition of
14 the Board's approval, the Applicant Cadence Health
15 agrees to amend the bylaws of Cadence Health
16 Foundation to add the following provision on the
17 closing date of September 1st, and that is that the
18 unrestricted gifts held by the corporation on the
19 effective date will remain -- I'd better just read it.

20 MS. AVERY: Read it.

21 CHAIRPERSON OLSON: "Any unrestricted
22 gifts that are held by the corporation as of the
23 effective date of the affiliation between CDH-Delnor
24 Health System, doing business as Cadence Health, and

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1 Northwestern Memorial HealthCare will continue to be
2 used in a manner consistent with the corporation's
3 charitable purposes for the benefit of the
4 institutions served by Cadence Health and/or the
5 population located within the Cadence Health's service
6 area."

7 And we would just ask that you would send a
8 copy of those bylaws to our staff so that we know that
9 that actually -- that transaction's taken place.

10 May I have a roll call vote, please.

11 MR. ROATE: Yes, ma'am.

12 Motion made by Mr. Bradley; seconded by
13 Mr. Galassi.

14 Mr. Bradley.

15 MEMBER BRADLEY: Yes.

16 MR. ROATE: Justice Greiman.

17 MEMBER GREIMAN: Yes.

18 MR. ROATE: Mr. Galassi.

19 MEMBER GALASSI: Yes.

20 MR. ROATE: Mr. Hayes.

21 VICE CHAIRMAN HAYES: Yes.

22 MR. ROATE: Mr. Sewell.

23 MEMBER SEWELL: Yes.

24 MR. ROATE: Chairwoman Olson.

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1 CHAIRPERSON OLSON: Yes.

2 MR. ROATE: That's 6 votes in the
3 affirmative.

4 CHAIRPERSON OLSON: The motion passes.
5 Good luck to you.

6 MS. ARDELL: Thank you.

7 CHAIRPERSON OLSON: Alteration requests
8 are none.

9 Declaratory rulings or other business, we
10 have E-01, Memorial Hospital-Belleville for a change
11 to the 2012 hospital profile.

12 Is there anyone here from Memorial Hospital
13 in Belleville?

14 (No response.)

15 CHAIRPERSON OLSON: May I have a motion
16 to approve the declaratory -- or the change of
17 hospital profile for the --

18 MEMBER GALASSI: So moved.

19 CHAIRPERSON OLSON: -- for Memorial
20 Hospital in Belleville?

21 I have a motion. May I have a second?

22 VICE CHAIRMAN HAYES: Second.

23 CHAIRPERSON OLSON: State Board staff
24 report?

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1 MR. CONSTANTINO: Thank you,
2 Madam Chairwoman.

3 The State Board staff is asking the Board to
4 approve a change in the 2012 hospital profile for
5 Memorial Hospital in Belleville.

6 What we are proposing is that the number of
7 ED stations, the total number of ER visits, the number
8 of trauma visits and admissions be included in the
9 2012 profile information. That was left out of that
10 when it was submitted by Memorial Hospital back in
11 2013.

12 Thank you, Madam Chairwoman.

13 CHAIRPERSON OLSON: Thank you.

14 And just as a note to the Board, we did --
15 because of the work of Nelson and the State Board
16 staff, we are catching these sooner and being more
17 efficient and effective about catching errors in that
18 profile.

19 So -- any other questions?

20 (No response.)

21 CHAIRPERSON OLSON: Seeing no further
22 questions, may I have a roll call vote on Item E-01,
23 Memorial Hospital -Belleville.

24 MR. ROATE: Thank you, Madam Chair.

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1 Motion made by Mr. Galassi; seconded by
2 Mr. Hayes.

3 Mr. Bradley.

4 MEMBER BRADLEY: Yes.

5 MR. ROATE: Justice Greiman.

6 MEMBER GREIMAN: Yes.

7 MR. ROATE: Mr. Galassi.

8 MEMBER GALASSI: Yes.

9 MR. ROATE: Mr. Hayes.

10 VICE CHAIRMAN HAYES: Yes.

11 MR. ROATE: Mr. Sewell.

12 MEMBER SEWELL: Yes.

13 MR. ROATE: Chairwoman Olson.

14 CHAIRPERSON OLSON: Yes.

15 MR. ROATE: 6 votes in the affirmative.

16 CHAIRPERSON OLSON: The motion passes.

17 Next up is Health Care Worker Self-Referral
18 Act, and there is no business under that.

19 Status report on conditional/contingent
20 permits, no business.

21 Applications subject to initial review, the
22 first one was 14-011, Maryville Academy/Scott Nolan
23 Hospital in Des Plaines.

24 That application has been withdrawn.

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FRESENIUS MEDICAL CARE GURNEE**

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1 Next, we have Fresenius Medical Care Gurnee.

2 May I have a motion -- the Applicant can
3 move to the table while we're doing this.

4 May I have a motion to approve Item 14-012,
5 Fresenius Medical Care Gurnee, to establish a
6 16-station ESRD facility in Gurnee? Discontinue a
7 14-station and establish a 16-station in Gurnee.

8 May I have that motion?

9 MEMBER GALASSI: So moved.

10 VICE CHAIRMAN HAYES: Second.

11 CHAIRPERSON OLSON: State Board staff
12 report?

13 MR. CONSTANTINO: Thank you,
14 Madam Chairwoman.

15 The Applicants are proposing the
16 discontinuation of a 14-station ESRD facility and the
17 establishment of a 16-station facility in Gurnee,
18 Illinois, at a cost of approximately \$5.5 million.
19 The anticipated completion date is December 31st,
20 2015.

21 There was no public hearing. We did have --
22 no opposition. We did have one finding on the size of
23 the project. The Applicants propose 750 gross square
24 feet per station. This exceeds our standard of 600 of

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1 about -- approximately a hundred gross square foot.

2 Thank you, Madam Chairwoman.

3 CHAIRPERSON OLSON: Thank you, Mike.

4 You need to be sworn in, please.

5 (Three witnesses duly sworn.)

6 THE COURT REPORTER: Thank you.

7 CHAIRPERSON OLSON: Comments for the
8 Board?

9 MS. MULDOON: Good morning. My name is
10 Coleen Muldoon. I'm the regional vice president --

11 MEMBER GREIMAN: Speak into the
12 microphone.

13 THE COURT REPORTER: We can't hear you.

14 MR. CONSTANTINO: Speak up.

15 MS. MULDOON: Okay. I'm the regional
16 vice president for Fresenius. And with me today is
17 Clare Ranalli, our counsel, and Lori Wright, our CON
18 specialist for Fresenius.

19 I want to thank the Board for their review
20 of our projects today, that we are presenting today,
21 and thank the Board members for their time.

22 We are pleased to come before you today with
23 an application that meets all of your criteria except
24 for size, which I will briefly address.

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1 The facility's size is a total of
2 1600 square feet over the Board's standard; however,
3 approximately a thousand square feet of this will be
4 used for the facility's growing home therapy
5 department and not our chronic in-center dialysis
6 base, which is what our standard applies to. So we
7 are really over about 50 square feet, which is a small
8 amount, particularly since administrative space will
9 be located in this facility.

10 Thank you. And I would be happy to answer
11 any questions you may have.

12 CHAIRPERSON OLSON: Questions from Board
13 members?

14 MEMBER GALASSI: I just --

15 MEMBER GREIMAN: Well, I just -- so let
16 me understand this.

17 So you have 14 and you're going to have 16,
18 so you're paying \$5 million for 2 more rooms? Is that
19 fair to say? Is that what you're doing?

20 MS. MULDOON: The facilities --

21 MEMBER GALASSI: Judge, you have to use
22 your mic.

23 MEMBER GREIMAN: Is that right?

24 MS. MULDOON: Yes. The facility that

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1 we're currently in has very limited space. We've been
2 in there for quite a long time. We've added stations.
3 It's way too small for the 14 stations that are
4 currently housed there.

5 If we had adjacent space, we would have
6 moved into it but we don't, so we didn't have any
7 other alternative but to relocate this facility.
8 We would have loved to just add additional space and
9 remodel the facility. It just wasn't possible.

10 MEMBER GALASSI: I noted that in this
11 facility your Medicaid is about 21 percent.

12 Is that comparable to most, or does it vary
13 significantly with your facilities?

14 MS. MULDOON: It varies. But it is
15 higher here and the -- and in this market in Waukegan
16 we do see it -- but we do have quite a few Medicaid
17 patients that do attend this facility or are dialyzed
18 at this facility.

19 MEMBER GALASSI: And the referrals all
20 come via docs? Do you get any referrals from the
21 community health centers that are there?

22 MS. MULDOON: Most of our referrals come
23 from our nephrologists.

24 MEMBER GALASSI: Yeah.

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1 Thank you.

2 CHAIRPERSON OLSON: Other questions?

3 (No response.)

4 CHAIRPERSON OLSON: Seeing no further
5 questions, may I have a roll call.

6 MR. ROATE: Motion made by Mr. Galassi;
7 seconded by Mr. Hayes.

8 Mr. Bradley.

9 MEMBER BRADLEY: Yes.

10 MR. ROATE: Justice Greiman.

11 MEMBER GREIMAN: Yes.

12 MR. ROATE: Mr. Galassi.

13 MEMBER GALASSI: Yes.

14 MR. ROATE: Mr. Hayes.

15 VICE CHAIRMAN HAYES: Yes, because this
16 is a relocation and the facility will justify the
17 addition of 2 new stations to 16.

18 MR. ROATE: Thank you.

19 Mr. Sewell.

20 MEMBER SEWELL: Yes. It meets all the
21 criteria except size, and on that I consider it fine.

22 MR. ROATE: Chairwoman Olson.

23 CHAIRPERSON OLSON: Yes, for the reasons
24 stated.

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1 MR. ROATE: That's 6 votes in the
2 affirmative.

3 CHAIRPERSON OLSON: The motion passes.
4 Thank you.

5 MS. MULDOON: Thank you.

6 MS. RANALLI: Thank you.

7 MS. WRIGHT: Thank you.

8 CHAIRPERSON OLSON: The next project is
9 14-013, University of Chicago Medical Center in
10 Chicago, if the Applicant can move to the table while
11 I get the motion.

12 Can I have a motion to approve
13 Project 14-013, University of Chicago Medical Center,
14 to build out shell space and add 12 intensive care and
15 29 observation beds at the hospital in Chicago?

16 May I have a motion?

17 MEMBER GALASSI: So moved.

18 MEMBER SEWELL: Second.

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

21 Mike, State Board staff report, then we'll
22 swear the Applicant.

23 MR. CONSTANTINO: Thank you,
24 Madam Chairwoman.

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1 THE COURT REPORTER: Thank you. And
2 please state your names as you speak so I can figure
3 out which one.

4 Thank you.

5 CHAIRPERSON OLSON: And unless it's
6 Smith, spell it, too.

7 MS. O'KEEFE: Madam Chairman, members of
8 the Board, I'm Sharon O'Keefe, O-K-e-e-f-e, and
9 I serve as president of the University of Chicago
10 Medical Center.

11 Joining me here today -- I will have
12 everyone potentially just -- how about just
13 introducing themselves for this hearing?

14 DR. WEBER: I'm Stephen Weber. I'm the
15 chief medical officer. Weber is W-e-b-e-r.

16 MS. ALBERT: I'm Debbie Albert,
17 A-l-b-e-r-t, patient care services and CNO.

18 MR. OURTH: Joe Ourth, legal counsel,
19 O-u-r-t-h.

20 MR. BEBERMAN: I'm John Beberman,
21 director of capital budgets. Last name is
22 B-e-b-e-r-m-a-n.

23 MS. O'KEEFE: Thank you.

24 Before I begin, I'd like to thank

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1 Mr. Constantino and members of his staff for the work
2 that they have completed on our application.

3 As you know, the University of Chicago
4 Medical Center is the only academic medical center
5 located on the south side of Chicago, and we're
6 located in one of the most economically challenged
7 areas of the state.

8 Seven years ago this Board approved our
9 application for a new hospital pavilion. Our new
10 hospital, titled now the Center for Care and
11 Discovery, opened in February of 2013.

12 With your approval and the opening of the
13 CCD, we have been able to serve the south-side
14 community with 240 new private patient rooms, as well
15 as state-of-the-art operating rooms and procedural
16 areas. Countless patients over the past year and a
17 half from our community have benefited from these
18 facilities and the technology that they offer.

19 The initial application for the CCD when
20 filed seven years ago approved shell space on the
21 third and fourth floor of that building with the
22 intent that this space would serve as future clinical
23 space and allow for the transition of additional
24 patient services to move from the Mitchell Hospital

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1 into the CCD.

2 As had been originally proposed, we are now
3 returning to the Board for approval to build out these
4 two shell floors for use as inpatient care.

5 The project that we are proposing has
6 essentially three components, which include the
7 relocation of 122 medical/surgical beds and
8 32 intensive care beds from the Mitchell Hospital into
9 the CCD; second component is the addition of 12 ICU
10 beds, which would be incremental; and the third
11 component is the creation of two ambulatory
12 observation units, which will total for us now
13 46 observation beds. This project would maximize the
14 full potential of our new hospital and allow us to
15 continue to meet the increasing health care demands of
16 our community.

17 We are pleased to have received a positive
18 State agency report with the exception of two minor
19 findings, which I will address in a moment.

20 The first component of our project deals
21 with the medical/surgical beds. At the completion of
22 this project, the medical center's total med/surg bed
23 complement will remain constant at 338 and we will
24 have approximately a little over 90 percent -- about

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1 92 percent of our beds will now be located in the CCD.

2 It was just last August of 2013, to
3 accommodate the critical capacity constraint we were
4 experiencing, that we were here before the Board to
5 seek approval to reactivate 38 beds in Mitchell which
6 had been decommissioned when we opened the CCD.

7 Reactivating these beds was actually a short-term
8 solution to quickly address the heavy utilization of
9 our med/surg beds and to assist in decompressing our
10 emergency department.

11 Those 38 beds have now been fully
12 operational since March of 2014. As our med/surg days
13 continue their steady increase, these incremental beds
14 have been highly utilized. In the past three months
15 since we've opened these beds, 69 percent of the days
16 we have operated at 80 percent occupancy or higher.

17 But interestingly enough, of equal
18 importance is the impact that those incremental beds
19 have had on our emergency services. With these new
20 beds we are pleased to report that, during the recent
21 three-month period, our emergency department has been
22 on diversion for a small amount of time -- actually,
23 13 hours for the three-month period of time -- which
24 is a substantial decrease from last year when we were

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1 averaging about 75 hours per month. And in spring we
2 actually enjoyed 84 consecutive days of being off
3 diversion and completely open to receiving patients
4 from the community.

5 As our med/surg base would now transition to
6 the CCD, we have a solid trend line of increasing
7 utilization, but we have not as yet met the State
8 standard, so let me address the State agency review
9 negative finding identifying that our utilization of
10 our med/surg beds did not meet the 88 percent
11 occupancy standard.

12 Since 2009 our med/surg days have increased
13 steadily. Most recently we are experiencing an
14 average increase of, year over year, approximately
15 6.3 percent growth. With this projected growth, we
16 would expect to achieve the State standard within
17 two years of completion of this project. Our
18 historical performance indicates with a high degree of
19 confidence that our med/surg beds will be effectively
20 utilized as we move forward.

21 The additional negative State agency review
22 finding indicated that the size of our rooms exceeded
23 the State standard. It exceeds the State standard by
24 36 square feet, which is approximately a 5 percent

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1 variance from the standard. There are three patient
2 care factors that actually explain this variance.

3 The first is that, per inpatient unit, we
4 add a second isolation room when the standard requires
5 one, and we believe that our patient population and
6 the acuity -- this is entirely consistent with the
7 patients that we serve.

8 The second is that each med/surg room has a
9 shower, which is not required by code but is something
10 that is certainly required from a patient satisfaction
11 standpoint.

12 And, in addition, we have added a nurse
13 alcove outside the patient room to support the use of
14 the electronic medical record and with respect for
15 patient privacy.

16 Each of these three issues contributed to
17 the modest increase in the size of the patient room.

18 The second component of our project proposes
19 to add 12 ICU beds, and we meet all utilization
20 criteria for the State. In fact, we currently reach
21 utilization levels that well exceed the State
22 standard. These incremental beds will allow us to
23 serve the demand for this level of care in our
24 planning area.

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1 The last component of our project addresses
2 the need for observation beds. We propose to increase
3 the number of beds from 15 to 46. While there
4 actually is no State standard for observation beds, we
5 anticipate that these beds will be heavily utilized,
6 above an 80 percent occupancy level, by the completion
7 of this project.

8 Both from advances in technology and a
9 growing patient population who are essentially not
10 well enough to go home but not clinically in need of
11 an admission, this population is growing. The demands
12 for these beds has essentially been increased with the
13 new rule from CMMS, which established guidelines for
14 admission to an inpatient bed. Since proliferation of
15 that rule, the observation patients at the University
16 of Chicago Medicine have essentially doubled since
17 last fall.

18 We believe the operational need for this
19 project is evident from our data analysis, which
20 outlines the increase in demand for services and a
21 clear upward trend in utilization.

22 Your approvals over the past years have
23 allowed us to remain fully operational and prepared to
24 meet the needs of our community. We ask your approval

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1 of our project and are now pleased to answer any
2 questions you may have.

3 CHAIRPERSON OLSON: Thank you.

4 Questions from Board members?

5 (No response.)

6 CHAIRPERSON OLSON: None?

7 I have a couple questions.

8 The . . . help me understand these
9 observation beds just a little bit more because, as
10 you know, earlier today we were told that you aren't
11 using any observation beds at all.

12 MS. O'KEEFE: Yeah. We actually have
13 quite a large population of observation patients, and
14 we tend to open our observation beds Monday through
15 Friday. When our census decreases on the weekends, we
16 don't have them in operation in order to maintain the
17 efficiency.

18 But Dr. Weber and Debbie Albert can perhaps
19 better describe which patients are increasing the
20 demand for this level of service.

21 DR. WEBER: Sure. I think we can both
22 speak to that point.

23 And, again, Sharon already mentioned the --
24 the move of more and more care to the outpatient

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1 setting is creating this population of -- for lack of
2 a better term -- in-between patients, those that, as a
3 clinician, I don't feel comfortable sending home but,
4 at the same time, may not warrant or now meet the
5 Federal standard in terms of an inpatient admission.

6 So the observation status would provide both
7 a geographical setting and proximity to our providers
8 so that those folks can receive a high level of care
9 and not someone who would be, for example, waiting in
10 the emergency room for appropriate placement or
11 sitting in a clinic waiting for a space to open up on
12 the inpatient side.

13 So we think it's a growing need. It's
14 certainly exacerbated by the change in the CMMS
15 expectations, but the experience over the last
16 six months has been very, very compelling in terms of
17 the numbers going up. It has doubled, as Sharon
18 already mentioned.

19 And, Debbie, do you want to say a little bit
20 about the types of the patients?

21 MS. ALBERT: Sure.

22 Primarily what we see in our observation
23 rooms are patients that come into our emergency
24 department, such as patients with -- chest pain

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1 patients, minor neurologic conditions that we can
2 observe, as Dr. Weber said, but, yet, aren't
3 comfortable enough with them going home for whatever
4 clinical reason.

5 So these -- this unit and then these
6 additional beds just give us the ability to serve
7 those patients, keep a closer eye on them so that we
8 can observe for potential complications rather than
9 have them go home and something happen.

10 CHAIRPERSON OLSON: And you're basing
11 your need for 46 of those beds upon your history in
12 the last six months when CMS changed its rule to --
13 because you have 12 now; is that right?

14 MS. ALBERT: We have a -- one inpatient
15 unit that's a 15-bed unit. When we look across all of
16 our care platforms, we actually have some of these
17 patients that are in our inpatient beds, as well.
18 So -- on a daily basis our current census is 30 to
19 33 observation patients throughout our entire
20 hospital, so these beds would just allow us to cohort
21 them more efficiently.

22 CHAIRPERSON OLSON: Okay. And then
23 I have another question. You have to educate a
24 country girl.

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1 How far is it from this Mitchell Hospital
2 where you're discontinuing beds to the UIC Medical
3 Center? And if I lived near Mitchell Hospital, what
4 will I do when you discontinue the beds there?

5 MS. O'KEEFE: So the beds that are being
6 discontinued in the Mitchell Hospital are moving into
7 the Center for Care and Discovery, which is a half
8 block away from --

9 CHAIRPERSON OLSON: With the same
10 payer mix?

11 MS. O'KEEFE: Oh, correct. Yes.
12 They're right on our campus.

13 It's probably -- I'm not a good judge of
14 distance but maybe . . .

15 MR. BEBERMAN: Maybe 15 minutes' travel
16 time, walking.

17 MS. O'KEEFE: Yeah. It's a walk of
18 probably about -- less than 10 -- 10 minutes or so.

19 CHAIRPERSON OLSON: From Mitchell to --

20 MS. O'KEEFE: CCD.

21 CHAIRPERSON OLSON: -- CCD?

22 MS. O'KEEFE: Yes.

23 CHAIRPERSON OLSON: So it's actually on
24 the same campus?

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1 MS. O'KEEFE: Yes. Absolutely, yeah.
2 Mitchell Hospital is, I would say, in the
3 center of our campus. And if you went just about a --
4 less than a 10-minute walk north and west, the Center
5 for Care and Discovery is right there on our campus.

6 CHAIRPERSON OLSON: And would you
7 anticipate that the staff from Mitchell would move
8 with those beds?

9 MS. O'KEEFE: Correct. Yes.

10 CHAIRPERSON OLSON: Other questions?

11 MEMBER GREIMAN: Yeah.

12 I -- Mitchell, as I understand it, is not
13 going to be used for medical purposes. It's going to
14 be office buildings actually; is that right?

15 MS. O'KEEFE: Right. A year or so ago
16 we did a master facility plan for our entire campus,
17 and that plan calls for migrating our inpatient
18 services, as I mentioned, north and west into the
19 Center for Care and Discovery.

20 The Mitchell Hospital is, oh, about a
21 33-year-old, 34-year-old building. And as part of
22 that master plan, by moving clinical services out, we
23 are going to retrofit that building for offices.

24 MEMBER GREIMAN: All right. So you're

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1 not going to be here next year asking for medical
2 rooms there; right? Is that right?

3 MS. O'KEEFE: Correct.

4 MEMBER GREIMAN: All right. Also . . .
5 I can't quite figure out the cost of this.

6 The cost we have is \$123 million. That's
7 for the whole building, I assume.

8 MS. O'KEEFE: It's for the -- it's
9 two floors in the CCD. It's approximately 200 -- each
10 floor plate in the CCD is a hundred thousand square
11 feet, so 200,000 square feet will be built out in the
12 CCD for the 123 million.

13 MEMBER GREIMAN: But the buildings are
14 already -- is already there; is that right?

15 MS. O'KEEFE: Correct. Yeah.

16 MEMBER GREIMAN: So what does it cost to
17 take the medical equipment, whatnot, from Mitchell and
18 install it in the new place? What does that cost?

19 MS. O'KEEFE: Yeah -- so let me kind of
20 back up.

21 When we built the CCD, the two floors -- the
22 third and the fourth floor that we're addressing to
23 build out now -- were actually completely shelled.

24 There is only skin around the building.

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1 There is no utilities, no infrastructure on those
2 two floors. So we're going to build those out
3 completely, build out the patient rooms, and then
4 relocate the patients.

5 MEMBER GREIMAN: I see. Okay.

6 Thank you.

7 VICE CHAIRMAN HAYES: Madam Chairwoman.

8 CHAIRPERSON OLSON: Yes, John.

9 VICE CHAIRMAN HAYES: Could you describe
10 how that -- your emergency trauma care -- you're at a
11 Level II; is that correct?

12 MS. O'KEEFE: Correct. We operate a
13 Level I pediatric trauma center and a burn center.

14 VICE CHAIRMAN HAYES: Okay. So where do
15 you -- so your patients, when they come -- when
16 they're adult trauma care, where do they -- they're --
17 basically bypass your hospital and go to where?

18 MS. O'KEEFE: The EMS or the first
19 responders will triage the patient, and Level I trauma
20 patients will go to one of the trauma centers in the
21 Chicago area, which are Christ, Stroger, Northwestern,
22 and . . . Mount Sinai.

23 VICE CHAIRMAN HAYES: Okay. Then -- you
24 know, you're actually -- although you do have a lot of

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1 patients in your area, in your -- that you describe
2 that you cover, and you mentioned about it's very
3 underserved, but, essentially, you know, you're not --
4 basically, they're being -- if you're an adult and
5 you're a Trauma I level, they will be going to these
6 hospitals which are, you know, far -- significantly
7 far away from you for -- a lot of your -- these
8 patients go to Christ Hospital, especially for -- in
9 Oak Lawn -- especially for, you know, serious gun
10 trauma; is that correct?

11 MS. O'KEEFE: Correct.

12 VICE CHAIRMAN HAYES: Okay. Well,
13 thank you.

14 MEMBER SEWELL: Bernard Mitchell had
15 semi private rooms; right?

16 MS. O'KEEFE: Yes, they do.

17 MEMBER SEWELL: So in your new -- oh,
18 I'm sorry.

19 So in this Center for Care and Discovery --

20 MS. O'KEEFE: Yes.

21 MEMBER SEWELL: -- it's all private
22 rooms?

23 MS. O'KEEFE: Correct.

24 MEMBER SEWELL: Now, does that have any

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1 implications for who will be admitted based on their
2 payer category?

3 MS. O'KEEFE: No, not at all.

4 As a matter of fact, in Mitchell, with the
5 opening of the CCD, we had converted all semiprivate
6 rooms to private rooms. So right now the University
7 of Chicago Medical Center operates 100 percent private
8 rooms for all patients.

9 Our growth that I had mentioned, year over
10 year, the growth in our patient population had
11 actually been proportional across all payer mix, and
12 the growth in our emergency department, by staying off
13 diversion, we are also, off diversion, seeing a much
14 greater volume of patients.

15 If I went back three or four years ago, we
16 would average maybe 120 patients a day. We're now
17 seeing, on average, 150 patients and peaking, on
18 certain days, at 170.

19 And, also, we're admitting a slightly higher
20 percentage of patients out of the emergency
21 department. Right now, we're averaging around 21 or
22 22 percent of all patients seen in the ED are
23 admitted. A few years ago it was probably closer to
24 about 16 percent.

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1 MEMBER SEWELL: And this difference in
2 terms of the beds requested versus the 304 that's
3 justified by occupancy, it is the -- you're saying
4 that the occupancy rates are increasing over time?

5 MS. O'KEEFE: Yes.

6 MEMBER SEWELL: How long before -- your
7 estimate, of course. How long before that catches up
8 to what your capacity will be for the 338, where you
9 meet the occupancy standard for this modernization
10 request?

11 MS. O'KEEFE: With our current growth
12 that we're at right now, we anticipate that we will
13 hit the 88 percent State standard within two years of
14 completion of the project.

15 MEMBER SEWELL: Okay. Thank you.

16 MEMBER BRADLEY: So can you put a date
17 on that?

18 MR. BEBERMAN: I can help with that.

19 MS. O'KEEFE: Sure, John.

20 MR. BEBERMAN: September 19th, 2017.

21 MEMBER GALASSI: We can't hear you,
22 John.

23 MR. BEBERMAN: We estimate that, by
24 September 19th of 2017, we will have reached

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1 88 percent if -- if the current four-year trend
2 continues.

3 MEMBER BRADLEY: When do you project the
4 completion date?

5 MR. BEBERMAN: Completion date of the
6 project

7 MS. O'KEEFE: Right now, the projected
8 completion of the construction and activation of the
9 building is around mid- -- let's say -- July of 2016.

10 So two years after that, 2018, we'd be at
11 the 88 percent.

12 MEMBER BRADLEY: So your choice for a
13 date is 2018 as opposed to his 2017; is that right?

14 MS. O'KEEFE: You said "'18," didn't you?

15 MR. BEBERMAN: '17.

16 MS. O'KEEFE: '17.

17 MEMBER BRADLEY: So you're saying you'll
18 reach capacity by what date?

19 MS. O'KEEFE: It's two years after the
20 completion. I think we may have a different date at
21 which we're completing the project here.

22 So, right now, we would expect to meet the
23 State standard with our growth by September 19th,
24 2017.

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1 MEMBER BRADLEY: Let's go through this
2 again.

3 MS. O'KEEFE: Okay.

4 MEMBER BRADLEY: The State report says
5 that you anticipate completion on September 20th of
6 2017; correct?

7 CHAIRPERSON OLSON: September 30th.

8 MS. AVERY: September 30th.

9 MR. ROATE: 30th.

10 MEMBER BRADLEY: September 30th --
11 whatever it is -- of 2017. That's the completion date
12 projected in the State report.

13 MS. O'KEEFE: That's the closeout of the
14 project.

15 MEMBER BRADLEY: Okay. They call it the
16 completion date.

17 Do you -- so you're now saying that you will
18 meet the occupancy date by two years after that date?

19 MS. O'KEEFE: I think the difference
20 here is the closeout of the project, as I understand
21 it -- John, you can comment on this -- is when we
22 would be declaring the project complete from the
23 State's point of view.

24 We will -- we are planning to occupy the

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1 building, with the construction being done, in around
2 mid- to third quarter of 2016 and then the project --
3 with all of the paperwork, et cetera -- being
4 completed in 2017.

5 So from occupancy of the building in 2016 to
6 2017 is when we would hit the State standard of
7 88 percent.

8 MEMBER BRADLEY: Well, that's not within
9 your -- two years of any date that you've given us
10 so far.

11 CHAIRPERSON OLSON: I think you have to
12 tell --

13 MR. OURTH: Oh, and let me try to --
14 I think the answer -- two years -- your rules require
15 that you meet that within two -- the second full year
16 following utilization, and that's what was certified
17 as part of the application.

18 What Mr. Beberman is saying is, actually,
19 it's going to occur in advance of that and the
20 specific date that it occurs -- so that it -- it
21 actually occurs faster than the two years.

22 MEMBER BRADLEY: Correct.

23 MR. OURTH: We certify the two years
24 because that's what's required by the rules, but the

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1 actual date will occur more quickly, on September --
2 page 129 of the application says that that will occur
3 on September of -- of '17.

4 MEMBER BRADLEY: Okay.

5 CHAIRPERSON OLSON: Other questions?

6 MEMBER SEWELL: (Indicating.)

7 CHAIRPERSON OLSON: Mr. Sewell.

8 MEMBER SEWELL: I wanted to ask
9 Mr. Constantino a question.

10 This rule about modernization is based on
11 historical utilization?

12 MR. CONSTANTINO: That's correct.

13 MEMBER SEWELL: Is it for multiple
14 years?

15 I mean, is there any trending factor that's
16 looked at in this -- it's just a point in time for the
17 most recent year when data is available?

18 MR. CONSTANTINO: That's correct.

19 MEMBER SEWELL: I see.

20 CHAIRPERSON OLSON: Mr. Carvalho.

21 MEMBER CARVALHO: Thank you.

22 Two things.

23 The first, when you were here last, you were
24 seeking some additional beds, and part of the

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1 justification for the use of the beds was, in fact, to
2 deal with the bypass issue, and we had a conversation
3 about that.

4 And I must admit at the time I was a little
5 skeptical because the number of beds you would have
6 with the addition was still smaller than the number
7 that -- before you were at the medical center -- the
8 hospital ran when it was having that really high
9 bypass number, so I wasn't entirely convinced that
10 adding beds was going to affect the bypass numbers.

11 So the first thing, as the Department of
12 Public Health, I want to really thank you for actually
13 accomplishing exactly what you set out to accomplish,
14 and it demonstrates that it had more to do with --
15 less to do with facilities and more to do with will.

16 So you brought the will, and the Board gave
17 you the facility, and the combination of not being on
18 bypass in your community is a real -- something the
19 Department of Public Health has wanted to see for
20 years.

21 So on behalf of the Department, I really
22 want to thank you for that.

23 The second question I've forgotten, so why
24 don't I skip it.

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1 I'll pass.

2 CHAIRPERSON OLSON: Anything else from
3 the Board?

4 (No response.)

5 CHAIRPERSON OLSON: Okay. I will call
6 for a roll call vote on Item 14-013, University of
7 Chicago Medical Center of Chicago.

8 MR. ROATE: Motion made by Mr. Galassi;
9 seconded by Mr. Sewell.

10 Mr. Bradley.

11 MEMBER BRADLEY: Under modernization,
12 our staff reviewed this project and does not feel that
13 the 338 beds is justified and that, instead, it should
14 be 304 as the top.

15 And for that reason, I vote no.

16 MR. ROATE: Thank you.

17 Justice Greiman.

18 MEMBER GREIMAN: I think it's very --
19 it's a large hospital and it's a large amount of
20 facilities, and I will vote aye.

21 MR. ROATE: Thank you.

22 Mr. Galassi.

23 MEMBER GALASSI: Yes.

24 MR. ROATE: Mr. Hayes.

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1 VICE CHAIRMAN HAYES: Because of the --
2 I'm going to vote yes.

3 The size of the project, their reason for
4 noncompliance there I think is -- their explanation
5 has been very reasonable. And this is a very
6 important and large medical center that provides a lot
7 of different services, so I think that they will be
8 able to use these beds.

9 So I'm going to vote yes.

10 MR. ROATE: Thank you.

11 Mr. Sewell.

12 MEMBER SEWELL: I note no because of
13 failure to meet the modernization criteria. There
14 seems to be a difference in the Applicant's
15 projections about occupancy and the historical
16 occupancy that's the basis for the 304 beds.

17 So I vote no.

18 MR. ROATE: Thank you, Mr. Sewell.

19 Madam Chair Olson.

20 CHAIRPERSON OLSON: I vote yes for
21 reasons stated by Mr. Hayes. I do believe that the
22 Applicant demonstrated that they would be able to use
23 the 338 beds.

24 MR. ROATE: That's 4 votes in the

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1 affirmative, 2 votes in the negative.

2 CHAIRPERSON OLSON: The motion does not
3 pass.

4 You need 5 votes to pass. You'll be given
5 an intent to deny.

6 MR. URSO: You'll have another
7 opportunity to come before the Board as well as to
8 supply additional information pursuant to denial.

9 Thank you.

10 CHAIRPERSON OLSON: Thank you.

11 MEMBER CARVALHO: Madam Chair --

12 CHAIRPERSON OLSON: Yes.

13 MEMBER CARVALHO: -- since the project
14 will be coming back, it occurred to me . . . I won't
15 be. As you know -- I spoke with you -- this will be
16 my last meeting. So one -- I remember now the second
17 thing I wanted to say.

18 CHAIRPERSON OLSON: Okay.

19 MEMBER CARVALHO: And sometimes I make
20 observations about applications because they're
21 beneficial for everybody's application.

22 This particular application in the section
23 regarding alternatives was incredibly thorough.

24 One of the things that I've harped on over the years

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1 is sometimes the alternatives are two stupid ideas and
2 then exactly what we want to do.

3 And this one actually seriously and
4 extensively looked into it, and I think you, as a
5 Board, should hold that as the standard for what you
6 get when people are supposed to be telling you what
7 their alternatives are, and this one was particularly
8 noteworthy.

9 Thanks.

10 CHAIRPERSON OLSON: Thank you.

11 And I agree. That's a section I always
12 review very closely.

13 The next item up is Project No. 14-014,
14 Proctor Community Hospital in Peoria, to discontinue
15 their open-heart category of service.

16 I would look for a motion to approve that
17 project.

18 MEMBER BRADLEY: So moved.

19 MEMBER SEWELL: Second.

20 CHAIRPERSON OLSON: I have a motion and
21 a second to approve Project 14-014, Proctor Community
22 Hospital in Peoria.

23 State Board staff report and then we will
24 swear in the Applicant.

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1 MR. CONSTANTINO: Thank you,
2 Madam Chairwoman.

3 The Applicants are requesting to discontinue
4 its open-heart category of service. There is no cost
5 to this project. The completion date is July 16th,
6 2014.

7 This was no public hearing, no opposition,
8 and no findings.

9 Thank you, Madam Chairwoman.

10 CHAIRPERSON OLSON: I will ask that you
11 swear the Applicant in.

12 But based on the fact that there is no
13 opposition or findings, I will give you a choice to
14 present or just open it to the Board for questions.

15 MS. SIMON: We'll just open it to the
16 Board for questions.

17 CHAIRPERSON OLSON: But we do need to
18 swear you in.

19 (Three witnesses duly sworn.)

20 CHAIRPERSON OLSON: State Board -- oh,
21 you already gave it. Okay.

22 Questions from the Board?

23 MEMBER GREIMAN: Yeah.

24 So . . . this is an open-heart surgery

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1 program that you've had; is that right?

2 MS. SIMON: Yes.

3 MEMBER GREIMAN: Now, in the last years,
4 we have the -- what is it? -- TRAV that has come
5 into -- has TRAV taken the place of open-heart surgery
6 so much that you're closing this?

7 MS. SIMON: No. That's an alternative
8 and, actually, a little bit of different anatomy, so
9 that is not the reason that we're closing this.

10 The reason we're closing this -- requesting
11 to close this -- is that volume of the services at
12 that hospital is very, very small.

13 MEMBER GREIMAN: But you'll still do
14 TRVA -- do TRAV?

15 MS. SIMON: We currently do not provide
16 TAVR at Proctor Hospital.

17 MEMBER GREIMAN: You don't do that? So
18 you will have -- do no heart work, then, basically,
19 except telling somebody "Don't run"?

20 MS. SIMON: No, we -- we still do
21 considerable cardiac work there and catheterizations.
22 And what we're asking to discontinue is the actual
23 open-heart surgery, revascularization program.

24 MEMBER GREIMAN: How many open-heart

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1 surgeries did you do last year?

2 MS. SIMON: 11.

3 MEMBER GREIMAN: And how many have you
4 done over the years? 11 is the right number?

5 MEMBER GALASSI: No.

6 MS. SIMON: No. Early, the program was
7 stronger and had more volume. And as catheterization
8 and stenting has replaced open-heart surgeries -- and
9 there are three programs in Peoria. They're declining
10 in volume today.

11 MEMBER GREIMAN: And doctors who are
12 cutting open hearts, where do they go?

13 MS. SIMON: I'm sorry?

14 MEMBER GREIMAN: The doctors who have
15 been doing the operations, where do they go?

16 MS. SIMON: They're still there. They
17 go into different areas of cardiovascular work, some
18 of that being TAVR and some of it being other types of
19 vascularization.

20 MEMBER GREIMAN: So you will still do
21 TAVR, though; right?

22 You'll still do that?

23 MS. SIMON: The surgeons will continue
24 to do the open-heart surgery, yes, in Peoria.

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1 MEMBER GREIMAN: I see. Okay.

2 All right.

3 MEMBER SEWELL: Madam Chair, I need to
4 be brought into the 21st century.

5 What is this other procedure, Judge, that
6 you're talking about?

7 CHAIRPERSON OLSON: What's a TAVR?

8 MEMBER GREIMAN: It's a procedure
9 that -- they go through veins and they are able to put
10 on a -- a -- change the artery and fix it up without
11 having the open-heart surgery where they've got to
12 break your ribs and tear open your body.

13 CHAIRPERSON OLSON: Thank you for that
14 clinical explanation.

15 (Laughter.)

16 MEMBER BRADLEY: Dr. Burden would be
17 proud of you.

18 MEMBER GREIMAN: I did this because
19 Dr. Burden's not here today.

20 CHAIRPERSON OLSON: Oh, okay. I see.
21 Well, I'm sure he'll appreciate you filling his shoes.

22 MEMBER SEWELL: I like your explanation
23 better than his.

24 CHAIRPERSON OLSON: Okay.

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1 Other questions from the Board?

2 (No response.)

3 CHAIRPERSON OLSON: Or of -- of the
4 Judge, talking to the Judge.

5 (Laughter.)

6 CHAIRPERSON OLSON: Seeing no further
7 questions, may I have a roll call vote.

8 MR. ROATE: Motion made by Mr. Bradley;
9 seconded by Mr. Sewell.

10 Mr. Bradley.

11 MEMBER BRADLEY: Yes.

12 MR. ROATE: Justice Greiman.

13 MEMBER GREIMAN: Well, as -- I'm
14 concerned about where heart patients will go to get
15 open-heart surgery, but we don't do it as much anymore
16 so I'll vote aye.

17 MR. ROATE: Mr. Galassi.

18 MEMBER GALASSI: Yes.

19 MR. ROATE: Mr. Hayes.

20 VICE CHAIRMAN HAYES: Yes. From the
21 State agency report, I didn't find any findings in the
22 amount of procedures being done at that hospital, and
23 I believe they'll be going to the other two hospitals
24 in Peoria to be able to do this open-heart surgery.

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1 MR. ROATE: Thank you.

2 Mr. Sewell.

3 MEMBER SEWELL: Yes, for reasons stated
4 by Mr. Hayes.

5 MR. ROATE: Thank you.

6 Madam Chair.

7 CHAIRPERSON OLSON: Yes, as well, for
8 the reasons stated.

9 MR. ROATE: That's 6 votes in the
10 affirmative.

11 CHAIRPERSON OLSON: The motion passes.

12 MS. SIMON: Thank you.

13 MR. GREEN: Thank you.

14 CHAIRPERSON OLSON: The next project --
15 and the Applicant can make their way to the table --
16 is 14-015, Carle Foundation Hospital in Urbana to
17 build out shell space in its hospital in Urbana to add
18 48 med/surg beds.

19 May I have a motion?

20 May I have a motion?

21 MEMBER GALASSI: So moved.

22 MEMBER BRADLEY: So moved.

23 MEMBER GALASSI: Second.

24 CHAIRPERSON OLSON: You can swear them

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1 in while we're waiting for the mic.

2 Just for the Board members, this is all
3 information that was received -- by e-mail? Is it in
4 our packet? E-mail.

5 THE COURT REPORTER: Would you raise
6 your right hands, please.

7 (Three witnesses duly sworn.)

8 THE COURT REPORTER: Thank you. And go
9 ahead and sign in -- or print your names, please.

10 CHAIRPERSON OLSON: Frank just has a
11 comment before we proceed.

12 MR. URSO: I just wanted to remind the
13 Board members to please explain their votes in detail,
14 why they're voting the way they're voting.

15 Thank you.

16 CHAIRPERSON OLSON: State Board staff
17 report, Mike.

18 MR. CONSTANTINO: Thank you,
19 Madam Chairwoman.

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

24 The cost of the project is approximately

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1 \$17.8 million. The anticipated project completion
2 date is January 31st, 2016.

3 We did receive two comments on the State
4 Board staff report that I passed out to you today.
5 They were also sent to you electronically.

6 There was no public hearing on this project.
7 There was opposition.

8 Thank you, Madam Chairwoman.

9 CHAIRPERSON OLSON: Thank you.

10 Comments for the Board?

11 Be sure to introduce yourself.

12 Oh, I'm sorry. We have to . . .

13 MR. URSO: Board members who received
14 these comments just now and also by e-mail in regard
15 to this project, you're going to have to make a
16 determination.

17 Do you want to accept those documents and
18 then consider this project, or do you want to accept
19 those documents and then submit those comments to your
20 staff for further analysis and, basically, defer this
21 project at this point in time?

22 So you have to make a decision on which
23 route you'd rather go at this point.

24 CHAIRPERSON OLSON: Comments from Board

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1 members?

2 MEMBER BRADLEY: I'm prepared to
3 consider it and vote on it.

4 CHAIRPERSON OLSON: Okay. I am, as
5 well. I've read the comments.

6 Okay?

7 MEMBER GALASSI: I am, as well.

8 CHAIRPERSON OLSON: Okay.

9 Let's just have a motion to accept these
10 comments --

11 VICE CHAIRMAN HAYES: (Indicating.)

12 CHAIRPERSON OLSON: Okay. I have a
13 motion.

14 Do we have a second?

15 MEMBER GALASSI: Second.

16 CHAIRPERSON OLSON: We'll just take a
17 voice vote.

18 All those in favor?

19 (Ayes heard.)

20 CHAIRPERSON OLSON: Opposed?

21 (No response.)

22 CHAIRPERSON OLSON: Motion passes. The
23 comments are accepted.

24 (Discussion off the record.)

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1 CHAIRPERSON OLSON: Oh, who made it?

2 VICE CHAIRMAN HAYES: (Indicating.)

3 CHAIRPERSON OLSON: You made a motion;
4 right?

5 I think --

6 VICE CHAIRMAN HAYES: Did you make the
7 motion?

8 MEMBER SEWELL: I don't think so. That
9 was a long time ago.

10 VICE CHAIRMAN HAYES: Okay. I made it.

11 CHAIRPERSON OLSON: Okay. Before you do
12 comments, would you please introduce yourselves.

13 I am remiss. I should have done that before
14 you were sworn in. But please introduce yourselves.

15 DR. LEONARD: Sure. I'm
16 Dr. Jim Leonard, family practitioner, president
17 and CEO of Carle.

18 MS. BEEVER: I'm Stephanie Beever, the
19 senior vice president for system strategic development
20 at Carle.

21 MS. FRIEDMAN: I'm Kara Friedman, legal
22 counsel for Carle.

23 CHAIRPERSON OLSON: Okay. You can go
24 ahead.

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1 DR. LEONARD: Are we good? Okay.

2 Well, first, I'll take just a few minutes of
3 your time. I want to paint a picture of what we're
4 trying to accomplish, a little bit about Carle and the
5 community that we live in, the region that we're in.

6 I want to thank the individuals who made the
7 effort to come here today to support the project, and
8 I want to thank the Board members for their time as
9 you allow me to discuss the need to -- for the
10 additional beds at our hospital.

11 These prepared comments, I hope, will answer
12 most of the questions that you have. Of course, we'll
13 be happy to answer any concerns that have been raised
14 by some of the testimony that was selective earlier
15 today and, quite frankly, intentionally distracting
16 comments.

17 Much like our recent ED expansion project,
18 the need for these beds arises based on the matter
19 that we brought before you in 2010 when some of you
20 were here. That was the integration that Carle Clinic
21 had to add over 300 physicians to our hospital system
22 at that time. We appreciated your unanimous support
23 and encouragement to become an integrated delivery
24 system at that time and we've become that.

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1 Since that time our organization has also
2 become tremendously dynamic because of this model as a
3 combined system, which does include a health insurance
4 plan which is not exclusive. We have a single,
5 integrated medical record platform, a hospitalist
6 model, and enhanced systems provide efficient
7 management of patients across the entire care
8 continuum.

9 Our medical staff now represents over
10 50 specialties in Champaign-Urbana, and the
11 integration has created a steadfast commitment to
12 quality and innovation across the organization, which
13 was highly attractive to our recruitment efforts for
14 all health care providers.

15 Relatively speaking, with the exception of
16 Champaign-Urbana -- you may or may not be aware --
17 east central Illinois is very rural, and that creates
18 a different set of circumstances to deliver care.
19 Across the nation there's a marked rural-urban
20 disparity in access to comprehensive care.

21 Carle serves as the clinical safety net for
22 19 smaller . . . is it just me, or is he adjusting --
23 okay.

24 Carle serves as the clinical safety net for

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1 19 smaller critical access and other community
2 hospitals in the region. This significantly reduces
3 disparities in access that might otherwise exist in
4 those communities.

5 Carle provides a level and scope of acute
6 care in east central Illinois. We work hard to be
7 good stewards of the community's health care resources
8 and Carle's new platforms that opened the door for
9 unique opportunities as we focus on quality outcomes
10 and the cost of care.

11 Earlier this morning you got to hear from
12 Dr. Jennifer Eardley, representing the University of
13 Illinois, describing a potential collaboration with
14 the university to develop a very specialized medical
15 college focusing on engineering and medicine, which
16 would facilitate innovation and train MD scientists
17 for generations to come and be the first in the nation
18 doing this.

19 This is just one of the many new
20 opportunities for our health system, our community,
21 and the region and -- because of the integrated system
22 that you approved four years ago.

23 We're a safety net hospital/provider also
24 economically speaking. Carle's employment of close to

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1 400 physicians and over 200 advanced practice
2 providers has allowed our organization to extend our
3 charity care program for all of the health services we
4 operate, which means that uninsured and Medicaid
5 patients are able to fully access primary care
6 specialty services and not just hospital services, as
7 you also heard this morning, from our Federally
8 qualified health care friends.

9 In 2013 Carle provided 44 million, at cost,
10 in charity care to the region's residents. In 2012
11 Carle provided 72 percent of all charity care and
12 70.5 percent of all Medicaid care in our D1 planning
13 area.

14 Our request today is to develop the space on
15 the ninth floor of our patient tower, which was
16 shelled during Phase 1 of construction. We shelled
17 the space rather than build it out to allow ourselves
18 time to ensure that our actual medical/surg
19 utilization was consistent with the bed projections we
20 were using six years ago when we came to you.

21 So contrary to other assertions today, we
22 see this project as a conservative approach to
23 addressing patient demand, giving them -- we might
24 have sought to develop these beds prior to reaching

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1 our target utilization levels.

2 We believe this approach is consistent with
3 the purposes of your Planning Act and rules. Based on
4 the fact that we waited until this year to file, we
5 meet your service demand criteria right now for
6 expansion of an existing service.

7 Another minute on growth trends: These beds
8 will allow Carle to address capacities that have
9 emerged over the past several years. Being the only
10 tertiary care hospital in a 40-county area, Carle has
11 experienced significant growth in our inpatient days
12 throughout this time. We've repeatedly expanded our
13 medical/surgical capacity pursuant to the State's
14 incremental medical bed expansion exception; however,
15 we've now reached a point where these periodic
16 increases are insufficient.

17 Carle saw a 27 percent increase in its
18 med/surg census from the 2010 to 2013 and had a 2013
19 medical/surg occupancy rate of 93 percent. This trend
20 is continuing. It's consistent with the letters of
21 support put in by numerous area hospitals that
22 you saw.

23 We have an increased number of referrals
24 from hospitals throughout the region, and as you can

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1 see, many of the hospitals we collaborate with view
2 our specialization and growth as a benefit, not as a
3 threat, and we try everything we can to help them keep
4 their care local whenever possible.

5 It's a great place to practice medicine.
6 That's why we're attracting many physicians in our
7 rural/semi rural area. And by leveraging that level of
8 specialization available at Carle, it helps -- a
9 lot -- everyone else in our region.

10 We're on par with many larger urban
11 hospitals, some of which you heard today, but we have
12 a lifestyle that's different, that is attractive to
13 some practitioners. Small community hospitals -- you
14 may or may not be aware -- are seeing their
15 specialists retire. They're unable to recruit
16 replacements. With diminished specialization, they're
17 increasingly reliant on us to provide more complex
18 services.

19 Carle's physicians are using and sometimes
20 developing cutting-edge techniques, including the
21 TAVR procedure, which you were just talking about, so
22 it's available in Champaign-Urbana because of us.
23 We have physicians practicing -- in spite of what you
24 heard today -- in 31 subspecialties that are otherwise

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1 unavailable in the planning area. I'd be happy to
2 elaborate on that if you'd like.

3 And then, in conclusion, Carle routinely
4 receives patient transfers from every hospital within
5 the D1 planning area. One-third of our med/surg
6 patients come from outside that more immediate area.

7 In fact, Presence relies on Carle to treat
8 patients that need specialized care that it doesn't
9 offer and, last year, the two Presence hospitals in
10 the area transferred nearly 1200 patients to us for
11 admission.

12 Carle's now unable to accommodate every
13 transfer request based on our capacity issue. We must
14 turn away patients on a regular basis because we don't
15 have the beds for them. When this occurs, these
16 critical patients are sent to distant facilities,
17 Indianapolis, Springfield, Peoria, St. Louis. These
18 additional times lead to delays in treatment and
19 impact patient outcomes, make care more fragmented.

20 As the region's only tertiary care provider,
21 it's critical that we add these beds to allow us to
22 properly serve the residents of east central Illinois,
23 and we ask that you approve our request today.

24 Thank you so much for your time and your

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1 undivided attention, and we're happy to answer any
2 questions.

3 Thank you.

4 CHAIRPERSON OLSON: Questions from Board
5 members?

6 Mr. Sewell.

7 MEMBER SEWELL: It seems that, in your
8 description of your -- I guess -- your primary service
9 area, that you have a disagreement with the way the
10 planning areas have been carved out for purposes of
11 certificate of need.

12 In other words, you -- I think you're
13 arguing that you draw from a larger area. Or am I
14 putting words in your mouth?

15 MS. FRIEDMAN: No. You are, in fact,
16 correct.

17 Actually, about 56 percent of our
18 patients come from the D1 planning area, which has
19 four hospitals located within it, two of which are
20 critical access hospitals, and then approximately
21 47 percent of our patients -- excuse me, 43 percent --
22 my math is not correct -- of our patients come from
23 outside the D1 planning area.

24 CHAIRPERSON OLSON: So that -- the

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1 comment was made earlier that you don't really have
2 physician letters to support your numbers.

3 Can you speak to that?

4 MS. FRIEDMAN: Yeah. You know, there
5 are three different criteria that we were potentially
6 able to utilize in order to document the need for this
7 project. The three were historical demand, projected
8 referrals, and rapid population growth.

9 And we received technical assistance from
10 staff to describe our historical growth to document
11 that this project was justified. And that was the
12 option that we selected, and that option does not
13 require physician referral letters.

14 CHAIRPERSON OLSON: Okay. Thank you.

15 The other question I had was that, based on
16 some of the testimony earlier -- and I realize you
17 guys are under oath and they were not under oath --
18 the accusation was made that you had actually told the
19 one health system that you would be more than happy to
20 purchase their hospital and turn them into something
21 else once this project passed and you -- the
22 indication was -- and then you took their patients
23 away.

24 Could you address that, as well?

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1 MS. FRIEDMAN: The conversation that
2 actually occurred was a conversation related to the
3 community needs assessment for 2014 that was just
4 completed. In our community we partner together with
5 all other health care providers, including the
6 Presence system and the other large physician group as
7 well as other community services.

8 Out of that community needs assessment came
9 a significant need -- or need and lack of services and
10 coordinated services to provide behavioral health
11 services.

12 The conversation was actually -- Presence
13 Covenant has an inpatient unit and provides
14 substantial services to our community in the
15 behavioral health space, and it was a request to
16 partner together to actually make that more robust,
17 not only our two facilities but with the other
18 community members, as well.

19 There was not a discussion about closure of
20 their facility to do this instead. It was development
21 of that program.

22 MEMBER GALASSI: I would just like to
23 comment that that context was very helpful, and it's
24 another reason why I believe, when we have public

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1 comment, we should not be accepting anyone making a
2 comment of someone else's because there's no context
3 to it. Or seldom is.

4 Thank you.

5 (Discussion off the record.)

6 MS. FRIEDMAN: I actually was the person
7 that was on the phone call with the Presence members,
8 as well, so I am speaking first person.

9 CHAIRPERSON OLSON: Thank you for
10 clarifying that.

11 Other questions?

12 MEMBER GREIMAN: Yeah. I was just
13 curious.

14 Your charity is incredibly large, way, way
15 large -- three times larger than most of the
16 communities that we see.

17 And is that because of the student
18 population that comes there? Is there -- do you deal
19 with a lot of U of I students? Is that what --

20 MS. FRIEDMAN: It's actually broader
21 than that.

22 In 2010, when our organization integrated --
23 so the physician practice became a part of the broader
24 interrelated system -- we expanded charity care to not

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1 only address hospital-based services but, also, we
2 covered the ambulatory visits, support services like
3 therapy services, et cetera, for our patient base.

4 So if you look at our data in the State
5 agency report, 25 million was for hospital-based
6 services this past year. 44 million was our total.
7 So the remainder of that actually related to
8 nonhospital ambulatory outpatient-related services.

9 MEMBER GREIMAN: Right. But my question
10 really is -- sort of reflects on the notion that you
11 have a lot of people in that area that may not have
12 health insurance. U of I students may not have health
13 insurance.

14 MS. FRIEDMAN: Certainly. We have
15 not --

16 MEMBER GREIMAN: So you may -- just
17 because of that, you may be getting more people
18 without insurance.

19 MS. FRIEDMAN: Sure. We have not
20 identified that as a significant impact at this point
21 in time. That would be possible but we have not
22 identified it.

23 MEMBER GREIMAN: All right.

24 CHAIRPERSON OLSON: Other questions?

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1 VICE CHAIRMAN HAYES: Thank you,
2 Madam Chair man.

3 Now, you just -- related to it is that a
4 couple of years ago you had a major -- or it may be
5 even more than a couple years ago -- you acquired a
6 significant physician practice, which is now part of
7 the Carlisle [sic] system.

8 And -- I mean, that has allowed you to not
9 only have a hospital base but, also, the physicians
10 and outpatient facilities; isn't that correct?

11 MS. FRIEDMAN: Correct.

12 VICE CHAIRMAN HAYES: Okay. Now, when
13 that came before this Board, that was somewhat
14 controversial, as well, for many of the same reasons;
15 is that right?

16 MS. FRIEDMAN: Actually -- no. It was
17 actually strongly supported at the time.

18 DR. LEONARD: Yeah. I . . . we were --
19 I was amazed how quickly we were in front of you and
20 part of -- Dr. Burden was very complimentary of what
21 we were doing and was very forward-thinking, and it
22 was a unanimous vote.

23 So it may have been one of our other
24 projects, but the integration, the coming together,

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1 was very supported.

2 VICE CHAIRMAN HAYES: Well, I understand
3 from the Board itself, but there were other comments
4 that were not as supportive of that.

5 But, anyway, let's not deal with that.

6 You know, basically, when you're talking
7 about charity care here -- you know, I'm not sure if
8 that is -- when you're looking at it from a hospital
9 alone, a lot of that has to do with these -- this
10 physician group, and I'm not sure if it's fairly high
11 compared to other hospitals.

12 Could you comment on that?

13 MS. FRIEDMAN: I don't think I understand
14 the question.

15 DR. LEONARD: Are you talking about
16 integrated groups versus a hospital? I'm sorry.
17 I'm not sure I --

18 VICE CHAIRMAN HAYES: Well, your charity
19 care that you're -- on -- in Table 2 here -- is going
20 to include -- doesn't that include both the hospital
21 and the physician group?

22 MS. FRIEDMAN: I believe that it does.

23 And if I could recall back to 2010, I think
24 the issue that was in controversy in the community was

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1 that the Carle Clinic, prior to becoming part of the
2 health system, was a for-profit medical group, and
3 that did not have a -- sort of a hospital-based
4 mission to provide charity care to its patients.

5 And so what the community wanted was
6 assurances that, once it became part of the system,
7 that they would get access to the physicians. And
8 that's exactly what happened, and that is part of the
9 reason that the charity care figures are so high.

10 DR. LEONARD: And we took a charity care
11 program at that time and moved it into the physician
12 group, which is more generous than the State
13 requirements, which may be why the numbers are high.

14 I'm sorry; I don't know how it compares to
15 some of the other integrated groups, if that were part
16 of your question.

17 VICE CHAIRMAN HAYES: And in 2010, when
18 you acquired the Carlisle physician group -- I think
19 that was it -- there were some -- you did not acquire
20 all the physicians? There was -- you know, there were
21 some physicians that were forced out of that and some
22 areas that -- some geographic areas -- that were
23 not -- especially physicians -- some physicians were
24 not part of that acquisition; is that correct?

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1 DR. LEONARD: When -- first off, the
2 shareholders of the Carle Clinic -- and I'm reaching
3 back here -- it was a unanimous vote to move ahead
4 with the integration. We had an individual ownership;
5 there were 200-and-some docs.

6 And I believe -- and I'm under oath so I'm a
7 little -- a little hesitant here. I think in the
8 first year we lost nine physicians. We did not --
9 there was no major exodus or physicians driven away.

10 I can think of one physician who chose to
11 leave and is still in the region, actually, so I --
12 there was no major change, and all physicians were
13 offered contracts.

14 VICE CHAIRMAN HAYES: Okay. So nine of
15 them did leave, then?

16 DR. LEONARD: For various reasons,
17 retirement, chose to dislocate. The one didn't want
18 to work at an integrated delivery system; he preferred
19 private practice.

20 But 9 out of over-200-some owners and at
21 that time over 300 physicians -- because many were not
22 owners -- to -- to lose 9 -- and only 1 or 2 maybe
23 for -- they didn't like the model -- we thought was a
24 wonderful outcome.

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1 And, again, it was to set the stage, really,
2 for today, where -- being able to recruit physicians
3 and have physicians want to come to your community was
4 a really big deal and very important to be able to
5 provide that kind of basic, really, sort of
6 subspecialty care.

7 VICE CHAIRMAN HAYES: Now, these other
8 hospitals that are directly in your service area and
9 in Champaign-Urbana, they are -- you know, they don't
10 have anywhere near the extensive physician network
11 that you -- that Carlisle now has.

12 MS. FRIEDMAN: That is correct. There
13 are basically two physician groups that are in our
14 local and immediate Champaign-Urbana area.

15 The other group is a group practice of
16 approximately a hundred providers versus Carle now has
17 approximately 400 physicians employed and about
18 200 advanced practice providers employed.

19 VICE CHAIRMAN HAYES: But that one that
20 has the -- the hundred-physician group, they still
21 refer quite a few patients to Carle, don't they?

22 MS. FRIEDMAN: Yes, they do, due to the
23 fact that we have a whole host of specialty services
24 that are not available within their practice.

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1 DR. LEONARD: We have an open medical
2 staff model, in that any physician that's
3 appropriately trained and educated can apply for and
4 get privileges at our facility.

5 VICE CHAIRMAN HAYES: Thank you.

6 CHAIRPERSON OLSON: Other questions or
7 comments?

8 (No response.)

9 CHAIRPERSON OLSON: Seeing none, I'll
10 call for a roll call vote, please.

11 MR. ROATE: Motion made by Justice
12 Greiman; seconded by Mr. Galassi.

13 Mr. Bradley.

14 MEMBER BRADLEY: Prior to voting, I want
15 to say one thing about the presentation we heard
16 earlier.

17 By using a classic quote, one of your
18 opponents would have associated you with the words
19 "corrupt" and "corruption." I think that was out of
20 line, and I think it was very badly planned on the
21 part of the opponent.

22 This is an institution which is highly
23 respected in the community and, in fact, is highly
24 respected in my community because of the health plan

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1 that it operates. They are sterling organizations and
2 they don't need to be smeared by people in casual
3 comments. I think they're doing great work.

4 Our staff reviewed 15 criteria, they met
5 14 of the criteria, and I'm very happy to vote yes.

6 MR. ROATE: Thank you.

7 Justice Greiman.

8 MEMBER GREIMAN: Yes.

9 I am incredibly impressed by the amount of
10 charity that you provide. It is significantly higher
11 than almost every other institute in the state that
12 I've seen in the time that I've served on this Board.

13 And I'm impressed by it. Obviously, you
14 service -- you acquire additional space to continue
15 the additional services you're giving.

16 And I will tell you that, when I went to
17 Champaign-Urbana, it was Carle Clinic -- it wasn't a
18 hospital; it was a clinic -- so it's come a long way
19 in the 55 years since then.

20 I'll vote aye.

21 MR. ROATE: Thank you.

22 Mr. Galassi.

23 MEMBER GALASSI: Yes, based on my
24 previous comments.

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1 MR. ROATE: Thank you.

2 Mr. Hayes.

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

6 MR. ROATE: Thank you.

7 Mr. Sewell.

8 MEMBER SEWELL: I'm voting no for
9 reasons stated by Mr. Hayes.

10 MR. ROATE: Madam Chair.

11 CHAIRPERSON OLSON: I'm going to vote
12 yes based on the positive criteria that the Applicant
13 met and based on their comments addressing the
14 opposition's argument.

15 I vote yes.

16 MR. ROATE: Thank you, madam.

17 That's 4 votes in the affirmative, 2 votes
18 in the negative.

19 CHAIRPERSON OLSON: The motion fails.

20 You will be receiving an intent to deny.

21 You have the opportunity to appear before the Board
22 again.

23 DR. LEONARD: Fine. Thank you.

24 CHAIRPERSON OLSON: It is now . . . it

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1 is now twelve o'clock. We will break for 45 minutes.
2 Is that enough for lunch?

3 We will reconvene at 12:45 in this room.

4 Thank you.

5 (Recess taken, 11:56 a.m. to
6 12:51 p.m.)

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**REPORT OF PROCEEDINGS -- 07/14/2014
COMMUNITY DIALYSIS OF HARVEY**

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1 AFTERNOON SESSION

2 MONDAY, JULY 14, 2014

3 12:51 P.M.

4 CHAIRPERSON OLSON: Okay. Apologies for
5 the delay. I know there are still people eating. We
6 gave them a few more minutes, but we will go ahead.

7 I believe that our next -- DaVi ta's here.
8 The next project is Project 14-016, Community Di alysis
9 of Harvey.

10 I need a motion to approve Proj ect 14-016,
11 Community Di alysis of Harvey, for change of ownership
12 of an 18-station ESRD facility in Harvey.

13 May I have a motion?

14 VICE CHAIRMAN HAYES: So moved.

15 MEMBER GALASSI: Second.

16 CHAIRPERSON OLSON: Okay. I have a
17 motion and a second.

18 Would you introduce yourself and be sworn
19 in, and then we'll have the State Board staff report.

20 MS. DAVIS: Penny Davi s.

21 MR. SHEETS: Chuck Sheets.

22 THE COURT REPORTER: Would you raise
23 your right hands, please.

24 (Two witnesses duly sworn.)

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COMMUNITY DIALYSIS OF HARVEY**

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1 THE COURT REPORTER: Thank you.

2 CHAIRPERSON OLSON: State Board staff
3 report, Mike.

4 MR. CONSTANTINO: Thank you,
5 Madam Chairwoman.

6 The Applicants are proposing to acquire
7 control of Community Dialysis of Harvey, an 18-station
8 ESRD facility located in Harvey, Illinois.

9 The proposed cost of the transaction is
10 approximately \$4 million. The completion date is
11 December 31st, 2014.

12 There were no findings, no public hearing,
13 and no opposition to this project.

14 Thank you, Madam Chairwoman.

15 CHAIRPERSON OLSON: Thanks, Mike.

16 In light of the fact that there is no
17 opposition and no findings, would you like to present
18 or let us open it up for questions?

19 MS. DAVIS: It's up to the Board. I'll
20 take any questions you might have.

21 CHAIRPERSON OLSON: Questions from the
22 Board members?

23 (No response.)

24 CHAIRPERSON OLSON: Seeing no question,

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1 I will call for a roll call vote on Project 14-016,
2 Community Dialysis of Harvey, in Harvey, Illinois, for
3 a change of ownership.

4 MR. ROATE: Motion made by Mr. Hayes;
5 seconded by Mr. Galassi.

6 Mr. Bradley.

7 MEMBER BRADLEY: In view of the fact
8 there are no findings and no opposition, I vote no --
9 I vote yes. I'm sorry.

10 MR. ROATE: Thank you.

11 Justice Greiman.

12 MEMBER GREIMAN: I vote yes because
13 there's no opposition to it, but I have my concern
14 about -- that the renal stations of our state will be
15 taken over by two companies and they'll own them all.

16 MR. ROATE: Thank you.

17 MEMBER GREIMAN: I'll vote aye.

18 MR. ROATE: Mr. Galassi.

19 MEMBER GALASSI: Yes, for the reasons
20 stated.

21 MR. ROATE: Thank you.

22 Mr. Hayes.

23 VICE CHAIRMAN HAYES: Yes, because the
24 application has met all the requirements of the State

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1 Board.

2 MR. ROATE: Thank you.

3 Mr. Sewell.

4 MEMBER SEWELL: Yes, for reasons stated
5 by Mr. Hayes.

6 MR. ROATE: Chairwoman Olson.

7 CHAIRPERSON OLSON: Yes, as well, for
8 reasons stated.

9 MR. ROATE: 6 votes in the affirmative.

10 CHAIRPERSON OLSON: The motion carries.

11 Congratulations.

12 MS. DAVIS: Thank you.

13 MR. SHEETS: Thank you.

14 CHAIRPERSON OLSON: Next up we have
15 Item 14-071, Skokie Hospital in Skokie.

16 I'm looking for a motion to approve a major
17 modernization project at the hospital in Skokie.

18 MEMBER GALASSI: So moved.

19 MEMBER SEWELL: Second.

20 CHAIRPERSON OLSON: Would you please
21 state your name for the Board and the reporter and be
22 sworn in.

23 MS. MURTOS: Good morning. My name is
24 Kristin Murtos, president of NorthShore Skokie

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1 Hospi tal .

2 MS. SKINNER: Honey Skinner with Sidley
3 & Austin.

4 MR. AXEL: Jack Axel with Axel &
5 Associates.

6 THE COURT REPORTER: Would you raise
7 your right hands, please.

8 (Three witness duly sworn.)

9 THE COURT REPORTER: Thank you. And
10 please print your names on the sheet, as well.

11 CHAIRPERSON OLSON: State Board staff
12 report, Mike.

13 MR. CONSTANTINO: Thank you,
14 Madam Chairwoman.

15 The Applicants are proposing the
16 modernization of med/surg beds, ICU beds, surgery,
17 same-day surgery, GI lab, PACU, and recovery rooms at
18 a cost of approximately \$107 million. The expected
19 project completion date is December 31st, 2017.

20 I'd like to give you a little background on
21 this project.

22 You, the Board, approved Permit No. 12-020
23 for this major modernization project for Skokie
24 Hospi tal .

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1 Subsequently the Applicants realized they
2 wanted to scale back the project from 154 million to
3 the current 107 million. They couldn't do that
4 through an alteration, so they had to come before you
5 and submit a new application for your approval for the
6 reduced cost and the reduced square footage, and
7 they're here today for that approval.

8 Once that approval is -- if they get
9 approved, I should say -- then the Applicants will
10 submit a project completion for the previously
11 approved project.

12 Thank you, Madam Chairwoman.

13 CHAIRPERSON OLSON: Thank you, Mike.
14 Presentation for the Board?

15 MS. MURTOS: Thank you.

16 We are here to present Project No. 14-017
17 and seek your approval to make modifications to our
18 modernization plan for Skokie Hospital.

19 You may recall that NorthShore acquired
20 Skokie Hospital from Rush in 2009, and at the time of
21 the acquisition, it was acknowledged that substantial
22 facility improvements would be required.

23 To that end, NorthShore engaged in a
24 detailed assessment of the hospital's facilities and

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1 the health needs of the community. The result was
2 Project No. 12-020, a \$157 million modernization
3 project which proposed 174,000 feet of construction
4 and 148,000 square feet of renovation.

5 The project was unanimously approved by this
6 Board on June 5th, 2012. We decided to phase in the
7 construction in order to minimize clinical disruptions
8 and to honor our commitment to continue providing care
9 to the patients in our community.

10 The postapproval planning for the project in
11 the initial phases of construction proceeded on
12 schedule with some phases already complete. To date,
13 approximately 20 million has been spent on that
14 project.

15 During the last year Skokie revisited
16 aspects of its facility plan and concluded that
17 certain cost savings could be realized and that
18 downsizing the original plan was justified.

19 At that time we reached out to your staff,
20 explained the reductions, and were advised by staff
21 that these changes should be proposed as part of a new
22 application. The application before you today,
23 No. 14-017, incorporates all these changes.

24 As noted, this new application specifically

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1 addresses those phases of the original 2012 project
2 that have not yet been completed. This application
3 proposes to maintain all of the clinical components of
4 the original project; however, we have chosen to
5 increase the renovation portion of the project while
6 reducing the new construction. This change alone will
7 reduce the project cost from 157 million to
8 127 million.

9 In addition, to make space for needed
10 services and consistent with the rules regarding the
11 beds that are justified based on documented
12 anticipated admissions, we propose a substantial
13 decrease in Skokie's number of beds.

14 The original 2012 Skokie application reduced
15 the hospital's beds from 195 to 156. This new
16 application will reduce beds even further, from 156 to
17 125 beds.

18 The findings in your State agency report are
19 identical to those of the original 2012 application
20 that was approved unanimously. We remain in
21 compliance with 17 of the 18 applicable review
22 criteria. The only negative review criteria is
23 1110.530(e), which compares historical utilization to
24 the number of proposed beds.

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1 As I have noted, we are proposing 70 less
2 beds than we were permitted when Rush owned the
3 hospital. Your staff found our project in compliance
4 with the review criteria that justifies the proposed
5 number of beds based on physician referral letters
6 that were included in our recently filed application.
7 A public hearing was not requested for this project
8 nor were any letters of opposition filed.

9 In summary, the request before you seeks to
10 reduce the number of beds by 31 and reduce project
11 expenditures by 30 million from our 2012 unanimously
12 approved project.

13 It is our intent, consistent with our
14 technical assistance consultations with your staff, to
15 file a final cost report to close out the original
16 project once all of the bills associated with the
17 initial phases have been received and paid and an
18 appropriate accounting is completed.

19 Thank you again for the opportunity to
20 address the Board, and I would be happy to answer any
21 questions.

22 CHAIRPERSON OLSON: Thank you.

23 Questions from the Board?

24 MEMBER BRADLEY: I have one.

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1 CHAIRPERSON OLSON: Yes.

2 MEMBER BRADLEY: So this facility was
3 known as Rush NorthShore; is that right?

4 MS. MURTOS: Yes.

5 MEMBER BRADLEY: Okay.

6 CHAIRPERSON OLSON: Other questions?

7 (No response.)

8 CHAIRPERSON OLSON: Seeing none, I'll
9 call -- I'm sorry.

10 MEMBER SEWELL: So even though you
11 overall reduced the number of beds from the original
12 project, you increased the number and the share of
13 your total beds that were medical/surgical beds; is
14 that correct?

15 MS. MURTOS: I'll ask Mr. Axel to speak
16 to that.

17 MR. AXEL: In the project that was
18 approved in June of 2012, we had 138 medical/surgical
19 beds out of the total 156 at the hospital.

20 We're proposing to remove 27 of those beds,
21 leaving 111 med/surg out of the 125.

22 MEMBER SEWELL: But according to the
23 State agency report, the historical utilization
24 justifies 105 medical/surgical beds.

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1 MR. AXEL: That is correct. That is why
2 we provided the letters from the orthopedic surgeons
3 that you find in your application.

4 MEMBER SEWELL: Okay.

5 CHAIRPERSON OLSON: Okay. Any other
6 questions or comments?

7 (No response.)

8 CHAIRPERSON OLSON: I'll call for a roll
9 call vote.

10 MR. ROATE: Thank you, Madam Chair.

11 Motion made by Mr. Galassi; seconded by
12 Mr. Sewell.

13 Mr. Bradley.

14 MEMBER BRADLEY: Based on the positive
15 State agency report, I vote yes.

16 MR. ROATE: Thank you.

17 Justice Greiman.

18 MEMBER GREIMAN: Because it appears to
19 be a thoughtful adjustment of a program that we
20 previously adopted, I vote yes.

21 MR. ROATE: Thank you.

22 Mr. Galassi.

23 MEMBER GALASSI: Yes, for reasons
24 stated.

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1 MR. ROATE: Thank you.

2 Mr. Hayes.

3 VICE CHAIRMAN HAYES: Yes, because of
4 the State agency report. And this is a contemporary
5 reduction in beds and looking at the scope of this
6 project and adjusting for that so I vote yes.

7 MR. ROATE: Thank you.

8 Mr. Sewell.

9 MEMBER SEWELL: I vote yes because it's
10 a substantial reduction to make the project in
11 line with our criteria.

12 MR. ROATE: Thank you, sir.

13 Madam Chair.

14 CHAIRPERSON OLSON: I vote yes, as well,
15 for reasons stated.

16 I think the reduction is -- shows great
17 effort on the part of the Applicant to follow through.
18 I vote yes.

19 MR. ROATE: Thank you.

20 That's 6 votes in the affirmative.

21 CHAIRPERSON OLSON: Motion passes.

22 Congratulations.

23 MS. MURTOS: Thank you.

24 CHAIRPERSON OLSON: Next we have 14-019,

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1 Fresenius Medical Care Summit.

2 May I have a motion to approve
3 Project 14-019, Fresenius Medical Care Summit, to
4 establish a 12-station ESRD in Summit?

5 MR. ROATE: Madam Chair --

6 CHAIRPERSON OLSON: Oh, I'm sorry.

7 Well . . .

8 MS. RANALLI: Do you want us here?

9 CHAIRPERSON OLSON: I skipped one. Talk
10 about pushing the agenda. Let's try that again.

11 Project 14-018. Were you guys panicking
12 over there?

13 MR. BOYD: I was like, "Wow. I've been
14 kicked out of places before but" --

15 CHAIRPERSON OLSON: McDonough County
16 Hospital District in Macomb.

17 May I have a motion to approve
18 Project 14-018, McDonough County Hospital District, to
19 approve the establishment of a 12-bed acute mental
20 illness unit on the campus of the hospital in Macomb?

21 May I have a motion?

22 MEMBER BRADLEY: So moved.

23 VICE CHAIRMAN HAYES: Second.

24 CHAIRPERSON OLSON: Now, if you would

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1 introduce yourself and be sworn in. My apologies.

2 MR. BOYD: Kenny Boyd, president and
3 CEO, McDonough District Hospital.

4 MS. DACE: Linda Dace, vice president of
5 finance, CFO, McDonough District Hospital.

6 MS. FOSTER: Wanda Foster, vice
7 president of nursing, CNO, McDonough District
8 Hospital.

9 MR. JESSEN: John Jessen, administrative
10 director, support services, McDonough District
11 Hospital.

12 THE COURT REPORTER: Would you raise
13 your right hands, please.

14 (Four witnesses duly sworn.)

15 THE COURT REPORTER: Thank you.

16 CHAIRPERSON OLSON: State Board staff
17 report, Mike.

18 MR. CONSTANTINO: Thank you,
19 Madam Chairwoman.

20 The Applicant is proposing to establish a
21 12-bed acute mental illness category of service on the
22 campus of McDonough County Hospital, Macomb, Illinois.

23 The cost of the project is approximately
24 \$3.2 million. The project completion date is

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1 December 31st, 2016.

2 There was no public hearing and no
3 opposition. We did have a finding on the size of the
4 project.

5 Thank you, Madam Chairwoman.

6 CHAIRPERSON OLSON: Thank you, Mike.

7 Comments for the Board?

8 MR. BOYD: Thank you, Madam Chairwoman.

9 The only comment I would have for the Board
10 before I open it up for questions is on the finding on
11 space.

12 In December of 2013 we came to the Board for
13 an expansion and modernization project of the
14 organization, which you approved. Inside of that was
15 shell space on the second floor of a three-story
16 addition. That space was designed based on the needs
17 of the first and third floor of that building. This
18 is the proposed project that we had mentioned at that
19 point in time going into that space.

20 There will be 12 private patient rooms with
21 private baths on this unit plus the clinical and
22 support spaces for that, including family areas.

23 We did not see it appropriate to utilize the
24 additional space for any others since it's a secured

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1 unit for the safety of the patients and they're being
2 treated inside of that facility. So, hence, the
3 reason that it is, on a per-bed square-footage size,
4 larger than your standards, but we believe it
5 appropriate based on the utilization needs of that
6 space.

7 So with that, I would open it up for any
8 questions from the Board.

9 Thank you.

10 CHAIRPERSON OLSON: Questions or
11 comments from the Board?

12 MEMBER GALASSI: A comment.

13 I just want to congratulate McDonough County
14 for getting into the behavioral health business. We
15 don't see it very often.

16 Good luck.

17 MR. CARVALHO: Yes. Actually, I have a
18 follow-up, sort of the same thing.

19 We see a lot of people going in and out of
20 AMI in the metropolitan area, and oftentimes the story
21 behind it is a . . . a physician's group moving from
22 one hospital to another. And then if you don't have a
23 physician to do admissions, there's no point in having
24 the facility.

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1 Is there something different that goes on in
2 your area that leads to your going into this line of
3 business? Or is it just addressing a local need?

4 MR. BOYD: It was addressing a local
5 need. We worked with two different organizations to
6 do assessments of the needs for mental health services
7 for the senior population and then identified an
8 extreme need inside of our area.

9 We're about 45 miles or right at an hour to
10 the nearest facility that provides the same services
11 to us, and, hence, the Board felt it appropriate, as
12 part of our mission, to address those -- to address
13 those needs with the implementation of this service
14 line.

15 CHAIRPERSON OLSON: Thank you.

16 Any other questions or comments?

17 (No response.)

18 CHAIRPERSON OLSON: Seeing none, I will
19 call for a roll call vote.

20 MR. ROATE: Thank you, Madam Chair.

21 Motion made by Mr. Bradley; seconded by
22 Mr. Hayes.

23 Mr. Bradley.

24 MEMBER BRADLEY: The staff reviewed them

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1 on 18 criteria, and they met all but 1, and I think
2 they've sufficiently explained that 1.

3 So I vote yes.

4 MR. ROATE: Thank you.

5 Justice Greiman.

6 MEMBER GREIMAN: For the reasons stated,
7 I vote yes.

8 MR. ROATE: Thank you.

9 Mr. Galassi.

10 MEMBER GALASSI: Yes, for reasons
11 stated.

12 MR. ROATE: Mr. Hayes.

13 VICE CHAIRMAN HAYES: Yes. I think that
14 this brings, you know, these services to this area,
15 and the closest unit that would be -- similar unit --
16 is 60 -- almost an hour away.

17 And they're also the -- they explained their
18 criteria that was mentioned in the State -- that they
19 did not meet in the State agency report on the size of
20 the project.

21 So I vote yes.

22 MR. ROATE: Thank you.

23 Mr. Sewell.

24 MEMBER SEWELL: I vote yes for reasons

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1 stated by Mr. Bradley.

2 MR. ROATE: Thank you.

3 Madam Chair.

4 CHAIRPERSON OLSON: I vote yes, as well,
5 for reasons stated.

6 And I compliment the Applicant on seeing a
7 need in your community and embracing it and going
8 after it. So I vote yes, as well.

9 MR. ROATE: 6 votes in the affirmative.

10 CHAIRPERSON OLSON: The motion passes.

11 Good luck to you.

12 MR. BOYD: Thank you.

13 MR. JESSEN: Thank you.

14 CHAIRPERSON OLSON: So now I will call
15 Project 14-019, Medical -- Fresenius Medical Care
16 Summit in Summit.

17 May I have a motion to approve
18 Project 14-019, Fresenius Medical Care Summit, to
19 establish a 12-station ESRD facility in Summit?

20 May I have a motion?

21 MEMBER GALASSI: So moved.

22 MEMBER SEWELL: Second.

23 CHAIRPERSON OLSON: Would you please
24 introduce yourselves and be sworn in.

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1 THE COURT REPORTER: Raise your right
2 hands, please.

3 (Four witnesses duly sworn.)

4 THE COURT REPORTER: Thank you.

5 CHAIRPERSON OLSON: Colleen, can you
6 introduce everyone?

7 MS. MULDOON: I will. Good afternoon.

8 My name's Colleen Muldoon. I'm the regional
9 vice president of Fresenius. With me is Clare
10 Ranalli, our counsel; Lori Wright, our CON specialist;
11 and Dr. Anderson has joined us today.

12 He provides care and treatment to our
13 patients in this medically underserved area that this
14 clinic will be located in, and he will support it with
15 his patient referral should it be approved.

16 We are pleased to come before you today with
17 an application that is unopposed and meets all of your
18 criteria except for the size of the facility. And as
19 I mentioned in the earlier project, the justification
20 for this size -- the 1900 square feet over the State's
21 standard -- is that of a thousand square feet due to
22 the home therapy department that we will be putting in
23 this facility. We don't put them in all of our
24 facilities, but both of those projects will have that.

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1 Our dialysis clinic will routinely plan for
2 and offer home therapy education, counseling, and
3 training, which requires that additional space. The
4 remainder of the coverage will be administrative use.

5 I'm going to hand it over to Dr. Anderson
6 just to see if you have any comments to add at this
7 point.

8 DR. ANDERSON: Sure.

9 I think the biggest point that we see is the
10 lack of open space and other close-by clinics. One of
11 the other clinics in the proximity is the Midway
12 Clinic, and that clinic is completely full. We have
13 patients there who would greatly benefit from the new
14 clinic proposed location.

15 We have one patient in particular who kind
16 of symbolizes the problems that we have, a very nice
17 guy, 35; he's been dialyzing since he was 20. As a
18 result, he's blind. He can't work, really, as a
19 result of that; he can't drive.

20 He's also gone on to develop multiple
21 myeloma, which is a type of bone cancer, so this poor
22 guy has had more health problems than anyone twice his
23 age should have. So he -- he struggles.

24 However, despite this, he has remarkable

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1 spirit. He never complains, always in a good mood,
2 always wanting to crack a joke; charming, charming,
3 wonderful man.

4 One day over the summer -- or I'm sorry;
5 over the winter -- he wasn't himself. He was very --
6 kind of upset, and it was very obvious, so I asked him
7 like what had happened.

8 So he went on to tell me the story that,
9 after his most recent dialysis, his transportation
10 never showed up. This was in January and it was a
11 terrible winter this year, so transportation was
12 inadequate, to say the least.

13 Sam waited for about an hour; no ride ever
14 showed up. Sam can be a little stubborn at times, so
15 he decided he was going to walk home. The clinic's
16 not very close, about 4 miles. But when you're blind
17 and you're weak after dialysis -- 4 miles took him
18 four hours in January. So he really struggled.

19 And despite that, he still -- the next day
20 he was back to his normal self. But, clearly, he's
21 one person who would benefit from this. He asked me
22 to please come tell his story because it's been a
23 struggle for him.

24 We have other patients with similar stories

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1 there, as well, who struggle. We have a 32-year-old
2 guy who is diabetic, has strokes. He lives very close
3 to the planned clinic, and he's very excited about the
4 possibility.

5 Despite having these strokes, he still
6 works. He works full-time. He has a hard time making
7 it to his treatments on time because he works.

8 There's also a multitude of traffic problems for him
9 because there's three trains, and I can attest to the
10 truth of this because I wait for them all the time
11 myself.

12 So sometimes he's stuck waiting for trains
13 and he comes late for treatment. And he comes in;
14 he's short of breath as a result -- after his
15 treatment, and he needs to come in again. It's very
16 difficult for him to manage these things.

17 So I think this extra clinic would provide a
18 lot of other options for some of these patients, and
19 I think it would be to many people's advantage to have
20 this facility available for them.

21 CHAIRPERSON OLSON: Thank you, Doctor.

22 MS. MULDOON: So thank you. We'd be
23 happy to answer any questions if you have any.

24 CHAIRPERSON OLSON: Questions from Board

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1 members?

2 MEMBER GREIMAN: Yeah.

3 I just -- I'm a little . . . sort of
4 off-kilter here with -- there's 75 -- 75 of station --
5 of outfits within the 30-minute run, 75.

6 MR. URSO: Can you use the microphone,
7 please?

8 MEMBER GREIMAN: Pardon?

9 MR. URSO: Can you use the microphone?

10 MEMBER GREIMAN: Oh, I'm sorry. Yeah.
11 75 of them. And 31 of them are yours, which
12 is a pretty significant number. Why do we need more?
13 Why do we need another one in this area?

14 And by the way, I already -- I think -- no,
15 I don't know how many of them yet -- 31 of them are
16 yours already.

17 Why do we need more?

18 MS. RANALLI: The State Board report,
19 Justice Greiman, gave us a positive with respect to
20 need and maldistribution because there is a need for
21 stations in the area.

22 And with respect to the issue I believe
23 you're raising on maldistribution, one of the
24 criterion that's specifically in your rules reflects

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1 that, if a facility is serving a medically underserved
2 population, then that is a justification with respect
3 to maldistribution that might otherwise exist in the
4 area.

5 And Summit has a 64 percent Hispanic
6 population; 20 percent of its residents are living
7 below the poverty level; less than half the population
8 has their own health insurance with two-thirds of the
9 population either uninsured or receiving Medicaid
10 benefits. And so that is the reason that we meet your
11 criteria, because we're going into this medically
12 underserved area where Dr. Anderson does see patients.

13 He did not mention but he told us that he --
14 that his practice just recruited a new fellow graduate
15 from the University of Chicago who is Columbian and
16 speaks Spanish, which is ideal, also, given the high
17 level of the Latino population in the Summit area.

18 I hope that answers your question.

19 MEMBER GREIMAN: Well, it answers it
20 only too directly because -- the direct answer is that
21 there are lots and lots of outfits that aren't meeting
22 the standards. And --

23 MS. RANALLI: But --

24 MEMBER GREIMAN: And so we're -- you

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1 know, we're giving you a pass, essentially.

2 MS. RANALLI: Well, but we meet your
3 rules because of the medically underserved area that's
4 specifically --

5 MEMBER GREIMAN: I understand.

6 MS. RANALLI: -- that's specifically
7 embedded in there.

8 And I think, again, that population -- and
9 Dr. Anderson can speak to this. Traveling out of the
10 community for a population like this is a heck of a
11 lot more difficult than maybe in some other areas
12 because of the economic disparity that exists.

13 MEMBER GREIMAN: Okay. Thank you.

14 DR. ANDERSON: If I may, the closest
15 clinics are full, so there aren't a lot of flexibility
16 for those patients. If they do miss a treatment for
17 whatever reason, they can't reschedule another
18 treatment because there aren't any other chairs
19 available. So that way, they will have to wait
20 another two days for their treatment, and that can be
21 dangerous, frankly, for a lot of these patients.

22 We do the best we can to care for them, and
23 sometimes we just need a little bit more assistance
24 and more flexibility for their schedules.

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1 CHAIRPERSON OLSON: Other questions?

2 VICE CHAIRMAN HAYES: Madam Chairman,
3 this is a direct question on -- to Mike Constantino.

4 Could you explain -- have we ever -- this is
5 something in the rules now? And how did this come
6 about about a medically underserved area? I'm not
7 sure if I've had that -- if we've had this with these
8 ESRD centers in the past, and I was wondering about
9 that.

10 Could you go into this a little more?

11 MR. CONSTANTINO: Yeah.

12 The Applicant provided the information
13 regarding this area, the Summit -- Summit Village,
14 it's called -- and we verified it, and it is a
15 medically underserved area -- population -- a
16 medically underserved population in that area.

17 VICE CHAIRMAN HAYES: So you verified it
18 there. Is this --

19 MR. CONSTANTINO: Right.

20 VICE CHAIRMAN HAYES: But this has been
21 identified by --

22 MR. CONSTANTINO: -- by the Applicants.
23 It was identified by the Applicant -- well, it was
24 identified by the Applicants in their application.

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1 They submitted their application for permit.

2 This is through the Federal government, this
3 identification of the medically underserved area -- or
4 population. That's a designation of the Federal
5 government.

6 And we went on the Web site and verified
7 that that is correct, it is a medically underserved
8 population in Summit Village, where this facility is
9 going to be located.

10 So we believe there is an access issue here.
11 There is a bed need, as calculated by our methodology,
12 and this is right on the border between HSA VI and
13 HSA VII. Both have station needs, calculated station
14 needs. We believe the facility was justified based
15 upon that information.

16 VICE CHAIRMAN HAYES: Does HSA VI
17 have -- is that medically underserved?

18 MR. CONSTANTINO: We --

19 VICE CHAIRMAN HAYES: And that is the
20 city of Chicago; is that correct?

21 MR. CONSTANTINO: That's correct. Yeah,
22 they have a station need. HSA VI has a station need.
23 This is right on the border of HSA VI and VII.

24 VICE CHAIRMAN HAYES: But is this --

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1 MR. CONSTANTINO: We only --

2 VICE CHAIRMAN HAYES: HSA VI, is that
3 medically underserved?

4 MR. CONSTANTINO: We only looked at --
5 Summit Village is the only thing we looked at as far
6 as a medically underserved population.

7 VICE CHAIRMAN HAYES: Now, did that also
8 include Argo?

9 MR. CONSTANTINO: No. We did not look
10 at Argo, no.

11 VICE CHAIRMAN HAYES: No -- Summit,
12 Argo? Is that what it was?

13 MR. CONSTANTINO: What we looked at was
14 Summit Village, what was termed "Summit Village."

15 VICE CHAIRMAN HAYES: Okay.

16 CHAIRPERSON OLSON: Aren't these done by
17 zip code? Right?

18 MEMBER SEWELL: Well --

19 CHAIRPERSON OLSON: Yes.

20 MEMBER SEWELL: -- I wanted to push this
21 thing a little bit on medically underserved areas
22 because it is HRSA, the Health Resources and Services
23 Administration of HHS, that approves these
24 designations, and they can be of varying geographies.

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1 And within a health service area you can
2 have critical manpower shortage areas, medically
3 underserved areas, depending on the set of indicators
4 that point to that. And these have been used
5 historically for deploying -- for allocating
6 resources, like National Health Service Corps
7 personnel, for instance.

8 And within the Illinois Department of Public
9 Health, I think there are staff people that sort of
10 advocate for different geographies around the state
11 because it's the gateway to resource allocation from
12 the Federal government.

13 So I just wanted to make sure --

14 VICE CHAIRMAN HAYES: No, that's a
15 good --

16 MEMBER SEWELL: The Applicant didn't
17 make this up. This is something that --

18 CHAIRPERSON OLSON: And it's based on
19 zip code; right? Because you could have a health
20 issue -- professional shortage area in a community
21 that has more than one zip code, and some of the
22 zip codes might be health professional shortage areas
23 and some of them would not be.

24 Correct, David?

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1 MR. CARVALHO: Well, fortunately, this
2 is in my office and it's actually in Bill's division,
3 so maybe we can help clarify.

4 But I thought there was some conversation --
5 is this a population or a geography? Because there's
6 both types.

7 There's designations of an area based on,
8 you know, the geography, but there's also designations
9 of populations within an area where the area itself
10 might not meet the criteria but the population.

11 And I thought you guys said it was
12 population.

13 MS. WRIGHT: It's both. I think it's
14 both. It's an area with a population.

15 And it is determined by -- in a census
16 tract, which is a little smaller than a zip code.

17 CHAIRPERSON OLSON: That's right.
18 That's right.

19 MS. WRIGHT: And a lot of the south side
20 of Chicago, southwest side -- you know, where Summit
21 is -- are medically underserved areas.

22 CHAIRPERSON OLSON: Thank you.

23 VICE CHAIRMAN HAYES: But don't you
24 have -- excuse me, Madam Chair.

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1 But aren't there areas very near there that
2 are -- would be overserved? And very wealthy areas?

3 DR. ANDERSON: Well, there --

4 VICE CHAIRMAN HAYES: I mean, Summit is
5 a very small area, and some of their -- actually, most
6 of their students even go to the -- a very good
7 high school in the area.

8 DR. ANDERSON: I think most of them go
9 to Argo High School. Again, there are --

10 VICE CHAIRMAN HAYES: No. They go to
11 La Grange. Don't they?

12 DR. ANDERSON: No. There's an Argo High
13 School right there.

14 VICE CHAIRMAN HAYES: I know Argo is
15 right there, but the Summit part goes to La Grange.

16 DR. ANDERSON: I don't know. I'm not
17 sure where they go.

18 MS. WRIGHT: No, they don't. Summit
19 goes to Argo. I know that because I live over near
20 that area.

21 CHAIRPERSON OLSON: Dale?

22 MEMBER GALASSI: Well, I think John's
23 point is, yes -- Lake County has five MUAs. So you'll
24 have North Chicago and then you'll have -- Lake Forest

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1 is right next to it.

2 So, yeah, it's very common -- it can be a
3 very small area, very small designation, but
4 legitimately meets the criteria here, which is really
5 the point of our conversation. It meets the MUA
6 criteria.

7 MEMBER SEWELL: Yeah.

8 MS. WRIGHT: Just from what I know of
9 the area, the immediate area, there's no wealthy
10 areas.

11 There's -- you know, it's working class;
12 it's near Midway Airport. I mean, if you go further
13 west from there, you fall into more wealthy areas, but
14 it's not the same health care service where they would
15 seek their services.

16 VICE CHAIRMAN HAYES: But this is near
17 the edge, the very edge of the city of Chicago, as
18 well.

19 MS. WRIGHT: Yes.

20 DR. ANDERSON: And if you were to drive
21 half an hour to the west or to the north, then you'd
22 get to very affluent areas, but that general area of
23 the southwest side of Chicago is -- you know, it's not
24 very wealthy. And it usually is medically

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1 underserved.

2 MS. RANALLI: And the zip codes being
3 served here, identified, were from -- the majority
4 were from the census tracts that are MUAs.

5 So I mean, it's -- the patients going to the
6 Summit clinic are not going to be coming from
7 30 minutes away. They're going to be right in that
8 area because we meet your criterion with respect to
9 50 percent or more of the patients residing in the
10 area to be served.

11 VICE CHAIRMAN HAYES: Okay. Thank you.

12 CHAIRPERSON OLSON: Other questions?
13 Comments?

14 (No response.)

15 CHAIRPERSON OLSON: Seeing none, I will
16 call a roll call vote to approve Project 14-019.

17 MR. ROATE: Motion made by Mr. Galassi;
18 seconded by Mr. Sewell.

19 Mr. Bradley.

20 MEMBER BRADLEY: The State Board report
21 says that 17 criteria were reviewed, 1 they didn't
22 meet. I think it's a minor one and they have
23 sufficiently explained it, and I think it's good to be
24 able to put this kind of facility in a medically

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1 underserved area and I vote yes.

2 MR. ROATE: Thank you, sir.

3 Justice Greiman.

4 MEMBER GREIMAN: I vote yes.

5 MR. ROATE: Thank you.

6 Mr. Galassi.

7 MEMBER GALASSI: Yes, based upon
8 comments made by Member Bradley.

9 MR. ROATE: Mr. Hayes.

10 VICE CHAIRMAN HAYES: I will vote yes
11 because the average occupancy for the 76 identified
12 facilities is at 70 percent, and I think that's close
13 enough, and they've also explained the criterion they
14 did not meet about the size of the project.

15 MR. ROATE: Thank you.

16 Mr. Sewell.

17 MEMBER SEWELL: I vote yes for reasons
18 stated.

19 MR. ROATE: Thank you.

20 Madam Chair.

21 CHAIRPERSON OLSON: I vote yes, as well,
22 for reasons stated.

23 MR. ROATE: Thank you.

24 That's 6 votes in the affirmative.

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1 MS. RANALLI: Thank you.

2 CHAIRPERSON OLSON: Motion passes.

3 Congratulations. Good luck.

4 MS. MULDOON: Thank you.

5 MR. CONSTANTINO: Madam Chairwoman, you
6 forgot about me.

7 CHAIRPERSON OLSON: What did I forget
8 about you?

9 MEMBER SEWELL: State agency report.

10 MR. CONSTANTINO: State agency report.

11 CHAIRPERSON OLSON: Oh, you didn't do
12 the report?

13 MR. CONSTANTINO: No.

14 MEMBER GALASSI: Save it.

15 CHAIRPERSON OLSON: Really? You could
16 have like waved at me sooner or something.

17 MR. CONSTANTINO: I just wanted --

18 CHAIRPERSON OLSON: It's not that we
19 don't need you, Mike.

20 MR. CONSTANTINO: I just have to report
21 to Chet. That's all.

22 CHAIRPERSON OLSON: Okay.

23 The next project is 14-020, DaVi ta Chi cago
24 Ri dge Di al ysi s i n Worth.

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1 May I have a motion to approve
2 Project 14-020, DaVi ta Chi cago Ri dge Di alysi s, to
3 establish a 16-station ESRD facility in Worth?

4 May I have a motion?

5 MEMBER BRADLEY: So moved.

6 CHAIRPERSON OLSON: Second, please?

7 VICE CHAIRMAN HAYES: Second.

8 CHAIRPERSON OLSON: Would you please
9 state your names and be sworn in.

10 MS. DAVIS: Penny Davi s.

11 MR. SHEETS: Chuck Sheets.

12 DR. PALLATH: Sreya Pallath.

13 CHAIRPERSON OLSON: Do you want to -- do
14 you need her to spell that?

15 THE COURT REPORTER: If you just sign on
16 the sheet, that's fine -- or print, please.

17 And raise your right hands, please.

18 (Three witnesses duly sworn.)

19 THE COURT REPORTER: Thank you.

20 CHAIRPERSON OLSON: Okay.

21 Mr. Constantino, we would love to hear the State
22 Board's report.

23 MR. CONSTANTINO: The Applicants are
24 proposing to establish a 16-station ESRD facility in

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1 Worth.

2 The cost of the project is approximately
3 \$3.5 million. There was no opposition and no public
4 hearing requested.

5 And we did have one finding regarding the
6 duplication/maldistribution of service.

7 Thank you, Madam Chairwoman.

8 CHAIRPERSON OLSON: That's it?

9 (Laughter.)

10 CHAIRPERSON OLSON: Comments for the
11 Board?

12 MS. DAVIS: Thank you very much.

13 First, I want to thank Mayor Werner of Worth
14 for coming out on our behalf today and Dr. Michael
15 Arvan, who spoke earlier in public testimony. He was
16 one of the partners of Dr. Pallath, who is here
17 with me.

18 I'd like to thank all of you who voted in
19 favor of this project when we were here previously,
20 and I really believe that this is the right kind of
21 project in the right kind of area.

22 The Chicago Ridge geographic area is
23 underserved when compared to the rest of the state.
24 17,205 ESRD patients or 27 percent of all the

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1 ESRD patients in the state reside within this
2 geographic service area; however, only 18 percent of
3 the approved stations are located there.

4 As of March 31st, the latest data available
5 from the Board, utilization of existing or approved
6 facilities within the area was 71 percent. This
7 includes that Nocturnal Dialysis Spa and NxStage
8 Oak Brook, which were approved at the November and
9 December meetings last year, respectfully, as well as
10 six facilities that have been operational for less
11 than two years. So FMC Oak Forest, FMC Cicero,
12 FMC Chatham, US Renal Oak Brook, and our Lawndale
13 facility have been -- are on the list but they've been
14 operational less than two years.

15 In fact, Lawndale, which just opened in
16 January -- December, was certified in January -- is
17 already treating 22 patients, which is 23 percent
18 utilization. We believe that that facility -- since
19 it increased 12 patients in just four months -- that
20 facility is going to be full at the end of 18 months.

21 And another dialysis facility, which is way
22 farther east -- and that is St. Anthony's dialysis
23 clinic -- that was just completed a year ago.

24 NxStage Oak Brook, which will be providing

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1 just respite and self-care dialysis, should not be
2 included as it is not operational and will provide
3 respite and self-care dialysis, not the traditional
4 three-time-a-week, in-center dialysis.

5 When you remove these facilities from the
6 average utilization calculation, the average
7 utilization of the existing facilities within the GSA
8 is actually 77 percent or just below the State
9 standard.

10 Facilities operational less than two years
11 shouldn't be included in the utilization analysis
12 because, under the Board's rule, we have two years to
13 bring a facility up to 80 percent.

14 Furthermore, dialysis facilities are really
15 physician-driven models. They principally serve the
16 primary physicians that refer to that center. It's
17 due to the fact that they're small centers when
18 compared to other health care facilities -- like
19 hospitals, nursing homes, and surgery centers -- which
20 can accommodate hundreds, if not thousands, of
21 patients.

22 A typical dialysis facility has 12 to
23 18 stations and only treats 58 to 86 patients, which
24 brings it to the 80 percent rule. Accordingly, a

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1 physician group like Dr. Pallath and Arvan's group,
2 which is called JR Nephrology -- which is currently
3 treating 179 Stage 4 and Stage 5 pre-ESRD patients and
4 they have referred 56 and 59 patients for dialysis in
5 each of the last two years -- we believe that they
6 will refer enough patients to fully utilize a dialysis
7 facility in that community within that period of time.

8 While we recognize there are facilities
9 within 30 minutes of Chicago Ridge that have capacity,
10 the primary service area for this physician group and
11 the patients they serve is much smaller than the
12 planning area designated in the rules. In fact, over
13 70 percent of the projected patients reside in an area
14 comprised of just 11 zip codes around the site.

15 Within the same service area, there are
16 nine dialysis facilities with overall utilization of
17 80 percent and only three below the 80 percent
18 standard: FMC Alsip is at 62 1/2, FMC Merriquette
19 Park is 68.8, and DSI Scottsdale is at 69 percent.

20 Collectively, these facilities can only
21 accommodate 60 additional patients, significantly
22 below the 113 that we believe JR Nephrology would be
23 referring to this center.

24 I want to briefly talk about home modalities

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1 even though it's not in the purview of the Board.

2 We're currently seeing a resurgence in the
3 home modalities, both home dialysis -- home
4 hemodialysis -- and peritoneal dialysis. In fact, the
5 Comprehensive ESRD Care Initiative demonstration by
6 the Centers for Medicare & Medicaid is encouraging
7 providers to increase the number of patients on home
8 dialysis.

9 We're committed to increasing access to
10 modalities beyond traditional in-center hemo. We're
11 the largest provider of home modalities in the
12 country. This year we have over 20,000 patients
13 nationwide on home modalities, an increase of over
14 2,000 patients over last year.

15 We will offer home hemodialysis, peritoneal
16 dialysis, and in-center dialysis at this facility.
17 Should the need arise for these -- for Dr. Pallath and
18 Arvan's patients, we would add nocturnal services.

19 Through our Patient Pathways program --
20 which we work with local area hospitals; it's a
21 provider-neutral acute care management and discharge
22 planning service -- we work with Advocate Christ
23 Hospital, which is in this community, to lower the
24 readmission rates.

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1 We accept in our chronic facilities
2 ER diversions. So that means that a dialysis patient
3 who shows up at the emergency room, fluid overloaded,
4 would normally be admitted to the hospital but,
5 because of our partnership with local hospitals, we're
6 able to take that patient over to the outpatient unit,
7 provide dialysis, and prevent that hospital admission.

8 It's estimated that we decreased the -- at
9 Christ Medical Center their readmission rate decreased
10 from 31.8 percent to 23.4 percent, resulting in an
11 average savings to the health care industry of
12 427,000.

13 We need additional stations to be able to
14 treat these emerging cases. They come anytime of the
15 day or night. When facilities are highly utilized
16 like the ones near Christ, it can be difficult to
17 locate a facility with an available station.

18 We also work with other area hospitals to
19 move these dialysis patients out of the hospital as
20 soon as possible. That means we need to have stations
21 available for the same-day discharge so that the
22 patient doesn't have to be dialyzed in the hospital,
23 which is far more costly.

24 I'd like to now turn the presentation over

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1 to Dr. Pallath to speak about her patient base and
2 issues with the rounding that her -- she and her
3 partners currently do at the various facilities.

4 DR. PALLATH: Good afternoon. My name
5 is Dr. Sreya Pallath, and I'm -- along with my
6 colleague, Dr. Michael Arvan, we are joint-venturing
7 with DaVi ta on the proposed Chi cago Ri dge Di al ysi s
8 uni t. I will also serve as the medical di rector for
9 the proposed uni t.

10 I wanted to take a couple of minutes to
11 explain why I am partnering with DaVi ta on this
12 project and why approval of this project is so very
13 vital to my patients.

14 My practice is very busy. Along with my
15 colleagues, Dr. Rydel and Dr. Arvan, we currently
16 treat over a thousand patients, both Stage 3, 4, and 5
17 chronic kidney disease patients, and that is an
18 increase of 293 patients or 37 percent since the
19 Chi cago Ri dge uni t appli cation was ori gi nally fi led.

20 While we work with patients to manage their
21 CKD and to delay the progression to end stage kidney
22 disease, unfortunately many of these patients do
23 progress and will likely initiate -- need to initiate
24 di al ysi s wi thi n the next one to two years.

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1 In addition to our chronic kidney disease
2 patients, we treat 194 ESRD patients who dialyze three
3 times a week at various dialysis centers.

4 Additionally, we have referred over 35 new patients
5 for in-center dialysis since the initial Chicago Ridge
6 application was filed, and, importantly, this number
7 is within the last six months of 2013.

8 My colleagues and I currently refer patients
9 to the three highly utilized facilities, to Stony
10 Creek Dialysis, which is operating at 86 percent;
11 Westmont Dialysis, which is operating at 86 percent;
12 and Beverly Dialysis, which is operating at
13 95 percent.

14 I anticipate that our practice will only get
15 busier within the years ahead. According to the
16 National Kidney Foundation of Illinois, over 1 million
17 Illinoisans have CKD and most do not know it. Kidney
18 disease is often silent until the late stages, when it
19 can be too late to head off dialysis and kidney
20 failure.

21 As more working families attain health
22 insurance through the Affordable Care Act and
23 1.5 million Medicaid beneficiaries transition from
24 traditional fee-for-service Medicaid to Medicaid

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1 managed care, more individuals are in high-risk groups
2 like low-income African-Americans and Hispanics, and
3 they will have better access to primary care and to
4 kidney screening.

5 Based upon the Centers for -- the US Centers
6 for Disease Control and Prevention, 10 percent of
7 American adults have some level of CKD. Therefore, we
8 anticipate tens of thousands of newly diagnosed cases
9 of CKD in the years ahead as a result of the health
10 care reform initiatives.

11 Once diagnosed, many of these patients will
12 be further along in the progression of their CKD due
13 to the lack of a nephrologist's care prior to the
14 diagnosis, so it is imperative that enough stations
15 are available to treat this new influx of ESRD
16 patients who will require dialysis in the next
17 few years.

18 Importantly, dialysis facilities do need to
19 be located close to where patients reside. The
20 majority of my patients live in Oak Lawn and in the
21 surrounding communities, including Chicago Ridge and
22 Worth.

23 Patients should be allowed to choose where
24 they dialyze, and to require these patients -- many of

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1 whom suffer many multiple comorbidities and they are
2 very debilitated. And to require them to travel 40 to
3 50 minutes to underutilized facilities in Elmhurst,
4 Downers Grove, and Mokena does not meet the needs of
5 those patients and is not an efficient use of the
6 health care resources.

7 And having a dialysis center proximately
8 close to the patient's home is key. When patients
9 travel excessive distances or spend time traveling to
10 dialysis centers, they miss their dialysis treatments,
11 and this results in noncompliance, which is
12 involuntary.

13 I'm partnering with DaVita on the Chicago
14 Ridge facility unit because of DaVita's clinical
15 reputation for excellence. DaVita has the lowest
16 mortality rate of any large dialysis provider. It has
17 the lowest 90-day catheter rate among large dialysis
18 providers. DaVita is the largest home hemodialysis
19 provider in the United States and will provide home
20 hemodialysis and peritoneal dialysis training programs
21 in Chicago Ridge.

22 DaVita is committed to offering alternative
23 modalities to traditional in-center dialysis, and this
24 is important to me and my colleagues. In fact,

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1 DaVita's PD program, the peritoneal dialysis program,
2 has grown by 19 percent year over year in Chicago.

3 Our practice is committed to providing
4 patients with alternative modalities, which includes
5 home hemodialysis and peritoneal dialysis, to ease the
6 stress and burden of dialysis on patients and their
7 caregivers. Patients on home modalities do not have
8 to travel to a dialysis center three times a week,
9 which is more important for my elderly and debilitated
10 patients who require transportation support.

11 We meet with our home dialysis patients once
12 a month to monitor their medical conditions and to
13 determine if changes to the dialysis prescription need
14 to be made. Additionally, they can control their own
15 bodies and choose when and how they will dialyze,
16 which will dramatically improve the quality of their
17 lives.

18 In-center facilities serve a vital role for
19 home dialysis patients as they periodically transition
20 to in-center dialysis for respite care. By providing
21 home therapies in the same building with an in-center
22 program, patients can come to the same facility for
23 the periodic checkups as well as for respite
24 treatment.

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1 Finally, I want to add that we understand
2 the importance of educating patients about other
3 treatment modalities, particularly transplant. Every
4 patient is counseled about transplant from their first
5 encounter or initial diagnosis. We encourage all our
6 patients to go to a transplant center for evaluation.
7 In fact, I'm on the medical staff at Christ Hospital,
8 and our office is located less than half a mile from
9 the hospital.

10 We work in concert with the Christ
11 transplant team, both prior to and after patients are
12 transplanted, to ensure a smooth transition from
13 dialysis to kidney transplant. Unfortunately, there
14 is a shortage of kidney -- of available kidneys, and,
15 according to the organ procurement and treatment
16 network, there are currently 4,630 individuals in
17 Illinois waiting for a kidney.

18 So, additionally, many of my patients may
19 also present later in the disease progression and they
20 are ineligible for kidney transplant due to their age
21 and other comorbidities.

22 So, in conclusion, I ask that you approve
23 this project for Chicago Ridge and allow myself and my
24 partners to continue to provide hemodialysis to our

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1 patients.

2 Thank you for your time.

3 CHAIRPERSON OLSON: Thank you, Doctor.

4 Questions? Comments from the Board?

5 (No response.)

6 CHAIRPERSON OLSON: I just wanted to --
7 Mike, I think, as Penny was going down this list, she
8 made some good points about the fact that some of
9 these have only been open for two years but yet -- so
10 I guess -- if you look on the list and see it's 0 or
11 15 percent or something, you can sort of surmise
12 that's probably the case, but I'm just sort of
13 wondering if there's some wisdom of -- of knowing
14 that -- would that be helpful to anyone else, as well,
15 or --

16 MR. CONSTANTINO: In the future you want
17 us to note that they --

18 CHAIRPERSON OLSON: Yeah. I mean,
19 I just think that would be helpful to realize that,
20 you know, if somebody's at 69 percent or 65 percent,
21 they've only been open for 12 months or -- because,
22 really, the standard is that they should be at that
23 target by two years. So I guess I'd surmise that,
24 until they hit two years, it's sufficient that they

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1 wouldn't be at that target.

2 Now, I know they're not going to ever get
3 there, but nobody -- if we keep proliferating -- but
4 I think it's important to note that . . .

5 (Discussion off the record.)

6 CHAIRPERSON OLSON: Well, that's a good
7 idea.

8 She suggested maybe doing a second chart and
9 putting the ones that have been open less than
10 two years within that radius so we still see them --
11 because I think it still needs to be factored in --
12 but I think it's a good point, that we can't expect
13 them to open next month and be at target.

14 And I just wanted to clarify from you,
15 Penny -- this is interesting to me after all these
16 applications we've been through -- a 12- to 18-station
17 ESRD facility would be full at between 58 and
18 86 patients?

19 MS. DAVIS: Correct. Yeah, if it's --
20 that would be at the 80 percent.

21 So if you assume six stations -- or
22 six shifts a week -- so that's Monday through
23 Saturday -- three shifts each day, and so that can
24 treat at 12 stations. I guess 6 times 12 is 72, would

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1 be maxed out. So 80 percent would be 58.

2 CHAIRPERSON OLSON: Other questions or
3 comments from the Board members?

4 VICE CHAIRMAN HAYES: Yes. I have a
5 question.

6 How far are you from Summit, Illinois? Do
7 you know that?

8 MS. DAVIS: Yes. It's about 15 minutes.
9 The patients, though -- as we -- because we do track
10 and -- as we do our applications -- look at particular
11 zip codes.

12 And so the zip codes of the patients in our
13 project and the zip codes of the patients in FMC's
14 project come from very different areas.

15 I have a map if you'd like to see it.

16 VICE CHAIRMAN HAYES: Okay. Well,
17 I understand that. But you're . . . you know, are you
18 a -- a -- do you have any idea of the mileage? Is it
19 about 5 miles away?

20 MR. CONSTANTINO: It's about
21 7 1/2 miles, John.

22 It's about 7 1/2 miles.

23 VICE CHAIRMAN HAYES: 7 1/2 miles?

24 MR. CONSTANTINO: From Summit, yes.

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1 VICE CHAIRMAN HAYES: Okay. And you're
2 saying that none of your patients are likely to come
3 from that area at all?

4 MS. DAVIS: Right.

5 MR. SHEETS: Well, Mr. Hayes, let me
6 address that a little bit.

7 Their -- if you look at their service area
8 and where their patients are coming from, it's pretty
9 much north and west -- say -- let's say Harlem and
10 95th. Okay? And ours are south and east of that
11 location.

12 So if you kind of look at it, it's like they
13 go out from two directions. So even though they're
14 close together -- or somewhat close together as far as
15 their location -- where the patients are coming from
16 are from the other direction.

17 VICE CHAIRMAN HAYES: Are your
18 patients -- have similar characteristics of that --

19 CHAIRPERSON OLSON: I've just been
20 reminded by legal counsel we need to be really careful
21 here that we're not comparing two projects.

22 VICE CHAIRMAN HAYES: No. I understand
23 that.

24 Are -- is your area medically underserved?

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1 MR. SHEETS: Well, since we've never
2 located that in the -- in the Board's rules, we didn't
3 address that criteria.

4 But I will say this: That if you look at
5 our area -- I mean, we go into Merriquette Park,
6 Alsip, Evergreen Park -- I mean, we're going east of
7 that area, and I know that area very well. And, you
8 know, I don't -- I don't know whether it's technically
9 medically underserved, but it's certainly in the same
10 demographic as Summit.

11 VICE CHAIRMAN HAYES: Okay. Would that
12 be -- do we have any idea if that has been designated
13 by the Federal government? I mean, they could be very
14 different economically and . . .

15 MS. DAVIS: We know from our patient
16 population at our Stony Creek facility, which is
17 nearby and is at 86 percent, that we have a high
18 Medicaid population and a very low commercial
19 insurance.

20 VICE CHAIRMAN HAYES: Now, what is
21 the -- because most of your patients are on Medicare;
22 is that correct?

23 MS. DAVIS: 90 percent are government
24 pay.

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1 VICE CHAIRMAN HAYES: But that isn't my
2 question.

3 You -- most of your patients will be on
4 Medicare. Who would be on Medicaid?

5 MS. DAVIS: Those patients who are not
6 eligible for Medicare, where they have not worked. So
7 if they have a -- don't have the quarters worked to be
8 able to go into Medicare.

9 We also have the undocumented. The
10 undocumented are covered under Illinois' emergency
11 Medicaid.

12 Some patients have both Medicare and
13 Medicaid.

14 (Discussion off the record.)

15 MEMBER GREIMAN: I guess I don't
16 understand something here.

17 You have -- you own four places which are
18 less than 12 miles -- 12 minutes away; is that right?
19 Am I right there?

20 MS. DAVIS: Well, 12 minutes --
21 Lawndale -- first of all, Lawndale is on here.

22 For those of you who know the city, Lawndale
23 is at the last -- 3900 west and . . .

24 MEMBER GREIMAN: No, I'm -- they're

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1 20 minutes away. And they're over by you, and none of
2 them are very close to being full occupancy.

3 So I don't quite understand this.

4 MS. DAVIS: The ones that . . . the
5 closest one is Stony Creek -- and that's
6 nine minutes -- that's 86. Palos is at 45 percent.
7 That is owned by us, and it's listed here as a
8 10-minute travel time. That's MapQuest travel time.

9 And those are actually -- those patients
10 come not from Christ Hospital but most likely -- most
11 often from Palos Community.

12 MEMBER GREIMAN: There's a Hoffman
13 Estates one and there's -- isn't that yours? --
14 Elk Grove.

15 MS. DAVIS: No, no, no. That's FMC,
16 Hoffman Estates.

17 MEMBER GREIMAN: Huh?

18 MS. DAVIS: Hoffman Estates is FMC,
19 Fresenius.

20 MEMBER GREIMAN: I see.

21 MEMBER GALASSI: That's pretty far.

22 MEMBER GREIMAN: Okay.

23 CHAIRPERSON OLSON: Other questions?
24 Comments?

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1 VICE CHAIRMAN HAYES: I'm done.

2 CHAIRPERSON OLSON: Okay.

3 Seeing no further questions or comments,
4 I will call for a roll call vote, please.

5 MR. ROATE: Motion made by Mr. Bradley;
6 seconded by Mr. Hayes.

7 Mr. Bradley.

8 MEMBER BRADLEY: I'm generally a
9 supporter of placing these in communities that need
10 them, and I think it's significant -- not only is our
11 State agency report okay with this, but I think it's
12 significant that no opposition has been expressed on
13 this and I vote yes.

14 MR. ROATE: Thank you.

15 Justice Greiman.

16 MEMBER GREIMAN: Aye for the reasons
17 stated.

18 MR. ROATE: Thank you.

19 Mr. Galassi.

20 MEMBER GALASSI: Yes, based upon need.

21 MR. ROATE: Thank you.

22 Mr. Hayes.

23 VICE CHAIRMAN HAYES: Yes. Based on the
24 State agency report, I notice -- I know that 10 of

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1 the -- 12 of the 18 centers or two-thirds are
2 operating at 70 percent, and this is within
3 20 minutes. So I would say the planning area need of
4 86 stations plus the stations that are closest to this
5 facility are operating at least at 70 percent, so I'm
6 going to vote yes.

7 MR. ROATE: Thank you.

8 Mr. Sewell.

9 MEMBER SEWELL: I vote no. The
10 application doesn't meet the unnecessary-duplication-
11 of-service and maldistribution criteria.

12 MR. ROATE: Thank you, sir.

13 Chairwoman Olson.

14 CHAIRPERSON OLSON: I'm actually going
15 to vote yes this time. I do believe that -- for the
16 reasons stated.

17 While there are facilities that are under
18 that target occupancy rate, I think the Applicant
19 explained well why some of them are not. I think
20 they're close to being there, and I think they
21 demonstrated the need very well.

22 MR. ROATE: Thank you.

23 That's 5 votes in the affirmative, 1 vote in
24 the negative.

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1 MS. DAVIS: Thank you.

2 CHAIRPERSON OLSON: Motion passes.

3 Congratulations.

4 MEMBER GALASSI: Good luck.

5 CHAIRPERSON OLSON: Good luck to you
6 guys.

7 MS. DAVIS: Thank you.

8 CHAIRPERSON OLSON: Next up we have
9 13-010. This is under applications subsequent to
10 intent to deny.

11 May I have a motion to approve
12 Project 13-010, Fresenius Medical Care Schaumburg, to
13 establish a 12-station ESRD facility in Schaumburg?

14 May I have a motion?

15 MEMBER GALASSI: So moved.

16 VICE CHAIRMAN HAYES: Second.

17 CHAIRPERSON OLSON: You guys have all
18 been sworn in.

19 Do they have to do it again?

20 MEMBER GALASSI: No.

21 CHAIRPERSON OLSON: Just introduce
22 yourself in case we forgot who you are.

23 MS. MULDOON: Colleen Muldoon, regional
24 vice president for Fresenius; Clare Ranalli, our

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1 counsel; and Lori Wright, CON specialist for
2 Fresenius.

3 CHAIRPERSON OLSON: Thank you.

4 State Board staff report, Mr. Constantino.

5 MR. CONSTANTINO: Thank you,
6 Madam Chairwoman.

7 The Applicants are proposing establishment
8 of a 12-station ESRD facility located in approximately
9 9400 gross square feet of leased space in Schaumburg,
10 Illinois. The cost of the project is approximately
11 \$4.8 million.

12 This project received an intent to deny at
13 the August 13th, 2013, State Board meeting.
14 Additional information was provided. And the State
15 Board staff notes there were three findings related to
16 this project.

17 Thank you, Madam Chairman.

18 CHAIRPERSON OLSON: Thank you, Mike.
19 Comments for the Board?

20 MS. MULDOON: Yes. Good afternoon
21 again.

22 Again, we've been before you with this
23 project multiple times, and we do realize that, but
24 I would like to briefly provide justification for the

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1 negative that relates to the maldistribution and
2 duplication of services.

3 We realize that nothing has really changed
4 since we were before you last with this project with
5 respect to the negatives; however, we believe one
6 justification to overcome the negative on
7 maldistribution is the Board-determined need for
8 stations.

9 Another justification is the historic high
10 utilization at our nearby Hoffman Estates and
11 Elk Grove facilities, both operating near capacity.

12 The DaVita Schaumburg unit has also operated
13 at high utilization rates historically and only very
14 recently added six stations to address that need for
15 additional access at that clinic.

16 The Schaumburg market is a densely populated
17 and congested area. And given the determined need and
18 the historic high utilization, we believe this project
19 is justified now since it will close -- it will be
20 close to two years before the facility is fully
21 operational.

22 As a result of the high utilization in the
23 area and the fact that the DaVita clinic will probably
24 be at target within 6 to 12 months, we believe

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1 patients will have barriers to access. They will have
2 to migrate outside of the area for care and will face
3 the lack of available shift choice.

4 Shift choice is not a convenience for some
5 patients. Schedule conflicts can mean limited
6 transportation options, loss of family time, and even
7 loss of employment.

8 Our proposed clinic will not be certified to
9 care for patients for one to two years if you approve
10 it today, which will mean the current excess capacity
11 at the DaVita clinic will probably be no longer
12 present and will be the right time for a new clinic to
13 be able to accept the 127 pre-ESRD patients identified
14 by Dr. Wick in our application who will need dialysis
15 in 2015 and 2016.

16 Thank you for your time, and I'd be happy to
17 answer any questions.

18 CHAIRPERSON OLSON: Thank you.

19 Questions from the Board members?

20 (No response.)

21 MS. WRIGHT: Could I just add that -- on
22 the heels of the last application -- there are
23 five facilities on the list that have been in
24 operation less than two years.

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1 CHAIRPERSON OLSON: Thank you.

2 Questions? Comments?

3 (No response.)

4 CHAIRPERSON OLSON: Seeing none, I will
5 call for a roll call vote.

6 MR. ROATE: Motion made by Mr. Galassi;
7 seconded by Mr. Hayes.

8 Mr. Bradley.

9 MEMBER BRADLEY: I believe this improves
10 access to the area and vote yes.

11 MR. ROATE: Justice Greiman.

12 MEMBER GREIMAN: I'll vote yes.

13 MR. ROATE: Mr. Galassi.

14 MEMBER GALASSI: Yes, growing need.

15 MR. ROATE: Mr. Hayes.

16 VICE CHAIRMAN HAYES: Oh, I'm going to
17 vote yes because, again, based on -- there are six of
18 nine facilities that are -- within 20 minutes -- are
19 at least operating at 70 percent capacity. So I think
20 there is a growing need for this in the future, and
21 I'm going to vote yes.

22 MR. ROATE: Thank you.

23 Mr. Sewell.

24 MEMBER SEWELL: I vote no. It doesn't

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1 meet the planning area need or the maldistribution
2 criteria.

3 MR. ROATE: Thank you.

4 Madam Chair.

5 CHAIRPERSON OLSON: I vote no for the
6 reasons stated by Mr. Sewell. I don't believe that
7 the need is there.

8 MR. ROATE: Thank you.

9 That's 4 votes in the affirmative, 2 votes
10 in the negative.

11 CHAIRPERSON OLSON: You --

12 MR. URSO: You're going to be receiving
13 a denial. You can avail yourself of due process if
14 you so desire.

15 MS. MULDOON: Thank you.

16 CHAIRPERSON OLSON: Thank you.

17 We have no other business; nothing under
18 rules development; unfinished business is none.

19 New business, Courtney. Cook County Health
20 System -- Health and Hospital -- oh, are they here?

21 They can come to the table.

22 MR. CARVALHO: Bye.

23 (Ex Officio Member Carvalho left
24 the proceedings.)

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1 CHAIRPERSON OLSON: Please state your
2 name for the court reporter and be sworn in.

3 DR. HAMB: Aaron Hamb, medical director,
4 Cook County Hospital.

5 DR. SHANNON: Dr. John Jay Shannon,
6 chief executive officer for Cook County Health and
7 Hospital System.

8 MR. DANIELS: Peter Daniels, chief
9 operating officer for the hospital-based services.

10 MS. REIDY: Elizabeth Reidy, R-e-i-d-y,
11 general counsel for the Cook County Health System.

12 THE COURT REPORTER: Would you raise
13 your right hands, please.

14 (Four witnesses duly sworn.)

15 THE COURT REPORTER: Thank you. Please
16 print your names on the sheet.

17 CHAIRPERSON OLSON: And, Mike, do you
18 have comments for us on this?

19 Or Courtney?

20 MR. CONSTANTINO: Do you want me to --
21 okay.

22 Cook County Health and Hospital Systems.
23 This is a temporary suspension of services at
24 Provident Hospital. This has been going on for some

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1 time. In fact, it dates back to 2008 even though we
2 did have a rule change. These services have not been
3 in place or have not been operating since 2008.

4 Under any -- the intent of the rule was not
5 to temporarily suspend services for six-plus years.
6 That was never the intent of the rule, and we're --
7 we've asked Cook County on a number of occasions what
8 their intent was with these services.

9 They have never submitted an application for
10 permit to discontinue these services. At one point
11 they said they needed the services, they need -- they
12 didn't need to do anything because they, in effect,
13 were going to bid on the Olympics; they needed that --
14 the utilization for the Olympics. They needed that --
15 services for the Olympics. I'm sorry.

16 And so they're now here before you, and we
17 would like for the Board -- to get an opinion of the
18 Board of what they want to do.

19 CHAIRPERSON OLSON: And, Frank, can I
20 ask you to clarify for the Board what the Applicant is
21 obligated to do at this point.

22 MR. URSO: Yes, Madam Chair and Board
23 members.

24 Essentially the Board needs to ask and --

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1 and get a response to questions.

2 And the first question is, has this project
3 proceeded in due diligence in terms of the temporary
4 suspension?

5 And the second question, if that's a
6 positive answer, then you need to be able to extend
7 the project if, in fact, due diligence has been
8 extended here.

9 So due diligence is the first one you have
10 to deal with.

11 CHAIRPERSON OLSON: Okay.

12 And you have a presentation for the Board?

13 DR. SHANNON: We do.

14 CHAIRPERSON OLSON: Okay.

15 DR. SHANNON: Thank you, Madam Chair and
16 members of the Board.

17 As stated when we were sworn in, I'm the new
18 chief executive officer for the health and hospital
19 system, having been voted into that position by the
20 Board on June 27th of this year.

21 CHAIRPERSON OLSON: Congratulations.

22 DR. SHANNON: Thank you. So I know --
23 I know everything. Ask me anything.

24 Dr. Hamb is our medical director at

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1 Provident Hospital. Peter Daniels is the chief
2 operating officer for hospital-based services, which
3 means that Stroger Hospital, Provident Hospital,
4 Cermak Health Services all report up to him
5 administratively for clinical operations. And
6 Ms. Reidy, as I think you know, is our general
7 counsel.

8 The Board's procedures -- we're before you
9 today respectfully to request an extension of the
10 temporary suspension of critical care and obstetric
11 services at Provident Hospital. As you know, the
12 critical care services were originally suspended in
13 October of 2010 and, subsequently, obstetric services
14 in February of 2011.

15 We -- the Cook County Health and Hospital
16 System has operated Provident as a community hospital
17 since 1993. We have a thriving regional outpatient
18 center on the campus that's now serving more than
19 60,000 ambulatory visits each year, and we are, even
20 as we speak, in the midst of a substantial investment
21 in diagnostic and therapeutic capabilities at the
22 Provident campus.

23 It's important to note, however, as we
24 invest in the campus, that the upgraded services have

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1 been designed to benefit our patients and the
2 Provident community that we serve regardless of the
3 final determination of the critical care or obstetric
4 services.

5 When the services we discuss today were
6 suspended, arrangements were made with the Stroger
7 Hospital, as well as other project -- as well as other
8 providers in the community, to address the needs of
9 the patients who present at Provident and who may
10 require urgent care for either -- hospitalization for
11 intensive care or obstetrics. We're confident today
12 that these arrangements continue to safely meet the
13 needs of the community.

14 Compelled by the dramatic reforms in health
15 care in our country, including the Affordable Care
16 Act, our health and hospital system is in the midst of
17 an unprecedented transformation of our health care
18 delivery model, and we feel very strongly that we must
19 remain flexible to meet the evolving needs of our
20 patients if we're to continue to deliver on our
21 mission of providing care to the medically vulnerable
22 residents of Cook County.

23 We have undertaken several important
24 initiatives that will help shape our future as a

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1 provider of health care in the county. I'd like to
2 outline several of those to the Board today to
3 demonstrate that due diligence with regard to the
4 temporary suspensions at issue.

5 With the support of the Federal government
6 and the State of Illinois and the commitment of the
7 Cook County Board, we established County Care, a
8 Medicaid managed care demonstration project to
9 early-enroll individuals who would be newly eligible
10 under Medicaid expansion under the Affordable Care Act
11 of 2014.

12 I'm proud to say that, in just over
13 16 months, more than 114,000 Cook County residents
14 have been approved for County Care. Many of these
15 were individuals who had been in the Cook County
16 Health System -- Cook County Health and Hospital
17 System -- over the years without any source of
18 reimbursement, and many were new to us.

19 Working closely with all of the Federally
20 qualified health centers in Cook County and the
21 hospital community, we've built a provider network
22 that would allow patients to accept -- to access a
23 broad array of health services in locations convenient
24 to where they live or work.

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1 That network today includes more than
2 135 primary care access points. This includes all the
3 Federally qualified health centers in the county and
4 the ambulatory and community health network of
5 Cook County Health and Hospital System primary care
6 access points. It includes more than 30 hospitals in
7 Cook County.

8 Significantly, in addition to operating
9 County Care, the health plan, the Cook County Health
10 and Hospital System is also a key provider of services
11 within that network. It is as a provider that we feel
12 we must make strategic -- certain strategic decisions
13 as to the best use of all of our existing facilities
14 to meet our patients' and the health care plan
15 members' needs.

16 With approval from the State on July 1st,
17 County Care transitioned to become a county managed
18 care community network, which will allow us to
19 continue to serve that ACA adult population but also
20 allows us to expand to include traditional Medicaid
21 members, such as those in Family Health Plan and
22 seniors and persons -- seniors and persons with
23 disability populations.

24 In total, we expect that the County Care

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1 membership could grow to 200,000 by the end of next
2 year. That is a significant health care plan by any
3 measure, and it requires a thorough understanding of
4 the members, their utilization patterns, where they
5 live, and their current and future health care needs.

6 The second and third initiatives are
7 planning efforts. One relates to our strategic plan
8 and the other around our central campus, which is
9 located in the Illinois Medical District.

10 In 2010 the Cook County Health and Hospital
11 System board of directors accepted Vision 2015, a
12 strategic plan for the health system. Since that time
13 there have been massive changes in the regional and
14 national health care environment. From the Affordable
15 Care Act at a national level to a movement by the
16 State of Illinois to Medicaid -- to managed care as
17 the dominant motif for Medicaid members in the county
18 of Cook to multiple leadership changes within Cook
19 County Health and Hospital System, much has changed,
20 and the current system board is well on its way toward
21 a revised strategy that thoughtfully considers these
22 and other changes that will guide us moving forward.

23 With County Care not -- now operating as a
24 Medicaid managed care entity, Cook County Health and

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1 Hospital System is evaluating the feasibility of
2 offering affordable plans on the health insurance
3 marketplace to ensure care for those who may move
4 between Medicaid and Federally subsidized plans.
5 Suffice it to say these are major considerations that
6 will take time to thoroughly evaluate.

7 The final strategic initiative I wish to
8 address pertains to our central campus.

9 It has been 12 years since we opened the
10 flagship Stroger Hospital, but our central campus
11 provides much more than simply those 464 inpatient
12 beds. The central campus is home to Fantus Clinic,
13 our general medicine clinic, and dozens of specialty
14 and diagnostic services. In fact, we see somewhere
15 between 2,000 and 3,000 ambulatory visits on our
16 central campus each day. Many of these facilities on
17 the central campus were built decades ago and do not
18 offer the modern health, technology, or comfort
19 amenities that our patients need and deserve.

20 With the support of Cook County Board
21 President Toni Preckwinkle and her team, we embarked
22 this spring on a planning process that includes a
23 comprehensive evaluation of our clinical space, both
24 on the central campus and across the entire system, to

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1 determine how best to deliver care in a post-
2 Affordable Care Act environment that places heavy
3 emphasis on ambulatory care.

4 These various moving parts, from leadership
5 changes to the exponential growth in our health care
6 plan, offer us the opportunity -- and, in fact, they
7 provide us with a very serious responsibility -- to
8 design our health system to ensure that we're
9 providing the right level of care to the right
10 patients at the right locations.

11 The major driver of these changes is the
12 Affordable Care Act, which, as you know, is, itself,
13 less than two years old. While we, as a system, find
14 that the Affordable Care Act has provided coverage to
15 so many people that we have served as uninsured
16 people, we must proceed cautiously and in a very
17 deliberate way to ensure that Cook County Health
18 System is positioned to provide the services most
19 needed by the patients we serve.

20 We can envision any number of scenarios with
21 regards to our patients' health care needs going
22 forward, and that includes, again, both our Medicaid
23 managed care plan, our County Care members, and the
24 non-County Care members that continue in very large

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1 numbers and who, themselves, move.

2 We simply need more experience in the new
3 managed care environment and more data about the
4 patients that we serve -- that we will serve. We're
5 confident that the coming year will provide us and me
6 with substantial information, data, and trends and,
7 therefore, guidance as to how best to define our
8 future role in the health care delivery system in
9 Cook County and how we can best utilize our existing
10 facilities to address those patient care needs.

11 We generally feel that it would be premature
12 to make a final decision on the critical care and
13 obstetric services at Provident Hospital before we
14 more fully understand the changes taking place in
15 health care in Cook County as a result of Federal,
16 State, and local activities and initiatives.

17 Again, just to put a dose of reality into
18 that, if, as anticipated, we bring in somewhere
19 between 50- and 70,000 Medicaid FHP lives onto our
20 plan over the next year and a half, about a third of
21 those are mothers. And where they would get their
22 prenatal care and where they would want to deliver
23 will be a very important strategic driver for us.

24 We have managed the temporary suspension of

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1 certain services at Provident responsibly, and we
2 continue to monitor our procedures to assure that we
3 provide that care to the community in a safe,
4 high-quality manner.

5 Therefore, we respectfully request your
6 approval, and we remain committed, as we have in the
7 past, to keeping the body updated and informed of all
8 of our progress and plans.

9 Thank you for your consideration, and we'd
10 be happy to answer any questions that you have.

11 CHAIRPERSON OLSON: Thank you.

12 I do need to, for the record, comment that
13 Mr. Carvalho left the room before anybody made any
14 comments on this application due to a conflict of
15 interest -- or this issue. It's not an application.

16 Questions? Comments from the Board?

17 MEMBER GREIMAN: Yeah.

18 How long is this extension for?

19 DR. SHANNON: We are requesting a
20 one-year extension.

21 MEMBER GALASSI: One year from now?

22 DR. SHANNON: That's right.

23 MEMBER GREIMAN: One year from this
24 date? And then what?

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1 DR. SHANNON: We submitted our request
2 in a letter to the staff of the Board on May 30th.
3 It's for smarter people than I to figure out when
4 would that become effective, but that was the date
5 that we submitted our request.

6 MEMBER GREIMAN: I mean, you're going
7 to -- you're going to be responsible for all of this
8 eventually anyhow, aren't you?

9 DR. SHANNON: Well, we're going to be
10 responsible for the care that I -- that I described
11 to you.

12 So, again, the health care system
13 currently -- if you look at our past calendar year --
14 took care of 350,000 unique individuals --

15 MEMBER GREIMAN: But you sent --

16 DR. SHANNON: -- as a provider. And
17 then --

18 MEMBER GREIMAN: But you sent lots of
19 them to other places because they were within this
20 group; right?

21 DR. SHANNON: That's correct.

22 So, again, within the Medicaid managed care
23 plan of County Care, about one-third of the members
24 are empaneled for their primary care with Cook County

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1 Health and Hospital System as a provider home; about
2 two-thirds of those members are empaneled at the
3 Federally qualified health centers across the county
4 as their medical home.

5 And we would anticipate, as we bring on
6 those traditional Medicaid populations -- as we
7 transition this month to a managed care community
8 network -- similarly, those new members will have a
9 choice about where they go for their primary care at
10 home.

11 MEMBER GREIMAN: Okay.

12 CHAIRPERSON OLSON: I actually have a
13 couple of questions, just along clarification, Mike.

14 It's my understanding that these services
15 were suspended in 2008.

16 MR. CONSTANTINO: Yeah. They were
17 reporting no utilization back in 2008, and these
18 services -- we considered that, after 12 months, they
19 discontinued their service.

20 CHAIRPERSON OLSON: So this February of
21 2011 date is not --

22 MR. CONSTANTINO: I don't know what that
23 means. But all I know from the information they
24 provided to us -- it went as far back as 2008 when

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1 they weren't providing any utilization for those
2 services.

3 CHAIRPERSON OLSON: So they've not had
4 new OB patients there since 2008?

5 MR. CONSTANTINO: Right. That's the
6 information we had.

7 CHAIRPERSON OLSON: So I guess . . .

8 DR. SHANNON: May we clarify that,
9 please?

10 DR. HAMB: My recollection is that we
11 actually suspended OB services at the end of 2010. We
12 actually had both outpatient and inpatient obstetrical
13 services in -- up to that time.

14 CHAIRPERSON OLSON: So -- but there was
15 no data on the questionnaires to indicate that.

16 MR. CONSTANTINO: No. And after
17 12 months --

18 CHAIRPERSON OLSON: So it's if -- it's
19 not documented in our records, though.

20 MR. CONSTANTINO: No.

21 And after 12 months we considered it
22 discontinued. We considered it discontinued after
23 12 months.

24 CHAIRPERSON OLSON: So -- and I do

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1 understand your view, Doctor, so -- with all due
2 respect -- but I also -- I mean, your -- you say
3 you're proceeding cautiously and you want to remain
4 flexible, but the reality is you're doing business
5 with the same health care environment that all the
6 rest of us -- myself included -- are doing business
7 in, and nobody knows what's going to happen. I mean,
8 that's about the only thing I think you can say.

9 So I guess I'm having difficulty reconciling
10 the fact that I'm supposed to find somehow that the
11 project has proceeded with due diligence, and I don't
12 see that. I mean, in your comments here today,
13 I think I heard the word "obstetric" mentioned once or
14 twice.

15 I don't see this vision plan of 2015 --
16 I mean, what I'm looking for -- what due diligence is
17 to me -- is something to indicate that, since 2008,
18 there's even been a discussion about the fact that "We
19 might reinstate these services" or that "We need to
20 discontinue them." I don't see any -- any
21 due diligence here.

22 Now, I understand that probably the
23 population that's in this County Care at this point is
24 the STD population, but you're anticipating that

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1 you'll put a product on the marketplace for the
2 general Medicaid popu -- Medicaid --

3 DR. SHANNON: No. Let me clarify that,
4 if I may.

5 So the demonstration that we had under the
6 Federal waiver that began in November of 2012 -- and
7 then was to sunset December 31st of 2013 but actually
8 had two extensions that actually took us to the last
9 day of June of this year -- was only for newly
10 eligible Medicaid adults. So it was a head start on
11 the Affordable Care Act population expansion that
12 happened January 1st of 2014.

13 It's only with our transition this month to
14 a State-administered managed care community network
15 that we're able to add those traditional Medicaid
16 populations -- the Family Health Plan populations and
17 the seniors and persons with disabilities -- to our
18 Medicaid managed care plan.

19 Now, we may have been taking care of a small
20 number of those two populations, the FHP and the
21 seniors or persons with disabilities, on a fee-for-
22 service basis, but I would point out that
23 traditionally our health care system has done a
24 diminishing number of obstetric care and deliveries

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1 over the last several years, but we think that that's
2 going to change substantially -- we just don't know
3 exactly how or where -- because, again, we will be
4 bringing on, we anticipate, somewhere between 50 and
5 70,000 of those FHP members.

6 In addition, those members who are currently
7 in our County Care plan as newly eligible adults, if
8 one of those members becomes pregnant, then they would
9 transition to -- they would become -- under State HFS,
10 they would become a Family Health Plan member --

11 CHAIRPERSON OLSON: I understand.

12 DR. SHANNON: -- but they would be
13 within our plan.

14 Now, again, we, as an organization, have not
15 taken care of a lot of deliveries in the past handful
16 of years, but with as many as 25 or -- 25,000 or more
17 new mothers that we could anticipate taking care of
18 across the county, determining where they would need
19 their services is a substantial challenge for us, and
20 those are people who we would not have traditionally
21 been seeing.

22 CHAIRPERSON OLSON: I understand.

23 That's exactly my point. I mean, that's a challenge
24 for all of us. I mean, I'm involved in an FQHC right

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1 now. We're sitting there taking -- "Where do we go
2 next?"

3 But at some point you have to anticipate and
4 make a move. I mean, flexible and cautious only go so
5 far. You're talking since 2008 and I don't really see
6 any evidence that anybody's made any -- at some point
7 you have to pull the plug one way or the other.
8 I think you have to say "We're going to get in or get
9 out of this market." We can't sit here for another
10 seven years with you anticipating and trying to be
11 flexible and cautious. I just don't see how we can do
12 that.

13 DR. SHANNON: Well, let me -- again,
14 I -- maybe I'm not being clear.

15 This gives us an opportunity -- the addition
16 of the Family Health Plan members to us as a Medicaid
17 managed care plan, it gives us more opportunity, first
18 of all, for covered lives that we were not taking care
19 of before except if you go by --

20 CHAIRPERSON OLSON: So based on
21 everything you're telling me, I'm not clear why you're
22 not sitting at the table today saying to me, "We are
23 going to reinstate these services because we have all
24 of this population coming and we know there are

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1 mothers that are -- or women of the age that they're
2 going to be pregnant." What do you -- I don't
3 understand what you're waiting for. I don't
4 understand --

5 DR. SHANNON: We have the -- Chair, we
6 have the population coming, but we don't know from
7 what neighborhoods; we don't know from what
8 backgrounds. And, again, one of the key features of
9 our managed care plan has been choice.

10 And so while we will have the ability to
11 shape, in a general way, utilization patterns for
12 those members, part of the reason for the success of
13 County Care as a Medicaid demonstration project has
14 been our partnering with other institutions, as I
15 pointed out, more than 30 hospitals and all of these
16 Federally qualified health centers.

17 So we have been trying not to dictate to
18 them, in part because we think it's bad business and
19 bad partnership with the people who have supported the
20 development of that plan but also because it's part of
21 choice.

22 So we don't know whether we should
23 anticipate are we going to see or would we be likely
24 to see, at either of our campuses, a substantial rise

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1 in the number of women who would choose to deliver
2 with us or whether they would, in fact, choose to go
3 elsewhere.

4 As I mentioned, in the adult population what
5 we saw is that two-thirds of the enrollees in adult
6 County Care chose, as a primary care home, one of the
7 Federally qualified health centers. Those Federally
8 qualified health centers themselves have utilization
9 patterns that are tied with, oftentimes, neighborhood
10 hospitals, oftentimes hospitals that they've had a
11 historical relationship with for some other reason,
12 and so it's determining those care patterns.

13 We don't -- to put it bluntly, we don't
14 anticipate being a successful FHP plan that would come
15 in and say, "Now, once you join us, you will deliver
16 at one of these two sites, Stroger Hospital or
17 Provident Hospital. Pick one." We don't think that
18 that's a recipe for success, and we don't think that
19 it's patient centered.

20 And in addition to that, we don't know
21 exactly even where the patients are going to come from
22 who would join us in FHP. I'll remind us that
23 Cook County is 1600 square miles. And so seeing the
24 dispersion of those mothers and families that join our

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1 plan is going to help us to determine what --
2 practically -- what would be a good choice for them.

3 That's why we still have to do discovery.

4 CHAIRPERSON OLSON: I understand what
5 you're saying.

6 DR. SHANNON: By the way, that
7 enrollment will only start this fall.

8 CHAIRPERSON OLSON: Right. Right.

9 MEMBER GALASSI: I commend your plan.
10 I really do.

11 CHAIRPERSON OLSON: Other questions and
12 comments?

13 MEMBER GALASSI: Yeah, I do --
14 I'm sorry.

15 I'm in support of your desire to have an
16 extension. I get that. And I think you are committed
17 on a path, as a team, with where you're going.

18 I'm just wondering, is June of '15
19 sufficient time for you to be able to be making the
20 kind of decision that the Chair would like to hear --
21 be hearing from you today?

22 DR. SHANNON: We hope that it is.

23 And, again, not criticizing the State at
24 all, but the original kickoff date for enrollment into

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1 managed Medicaid for those traditional populations
2 that I alluded to was July 1st.

3 And because of all the busyness and
4 complexity that 2014 has brought, those letters around
5 the enrollment into a Medicaid managed care plan -- as
6 I think you all know -- look like they'll be coming in
7 later, starting in September.

8 We'll see. I mean, it's going to depend a
9 lot on how that rolls out. It's our understanding
10 that, across the county, those letters will go out in
11 waves that will begin September 1st but will be
12 completed by the end of December. So we should see
13 those traditional populations empaneled by -- let's
14 call it -- March of next year if everything goes well.

15 So it's ambitious. I hope we're not having
16 to come back for another extension, but I -- but we
17 want to be practical, too.

18 And we -- and we recognize that we're one of
19 the earlier groups that's coming back to you under
20 your procedures, asking you for an extension of the
21 suspension so we -- we picked that one year as a
22 practical but arbitrary extension.

23 MEMBER GALASSI: Thank you.

24 MR. URSO: Let me just clarify for the

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1 Board members.

2 It cannot exceed one year per your rules.

3 So the extension can only run for one year --

4 MEMBER GALASSI: Thank you.

5 MR. URSO: -- per your rules.

6 CHAIRPERSON OLSON: Other --

7 Mr. Bradley.

8 MEMBER BRADLEY: First of all, I think
9 what the gentleman is not saying -- in addition to the
10 fact that he's brand-new and that's a difficult spot
11 to be in -- is he is trying to balance the actions of
12 three huge bureaucracies, the Federal government, the
13 State government, and County government, all of which
14 have bureaucratic agendas which are not necessarily in
15 line and some of which have political agendas which
16 are subject to change in elections.

17 So I think they are doing a remarkable job
18 for an institution that's been very highly done in the
19 past, looking at the future.

20 You may not know this, but my career for the
21 last 15 years before retirement was running the only
22 MCCN in Cook County and, in fact, in the state of
23 Illinois.

24 And I think you are accomplishing remarkable

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1 things in moving a population into this and in getting
2 prepared for what I think you've correctly diagnosed
3 as the future. However long it takes and however it
4 shakes out, I think Cook County is doing the right
5 thing in this area. I think, ultimately, you will
6 have more enrollment than you imagined.

7 And I think the only thing that is assured
8 is that the people in the area around Provident
9 Hospital will continue to have babies and they'll
10 continue to need someplace to go. And that was our
11 feeling when these services were suspended, and I
12 think you'll find that's the situation when you
13 ultimately decide to bring these services back.

14 So I wish you well in this endeavor.

15 MEMBER GALASSI: Well said.

16 CHAIRPERSON OLSON: Other questions or
17 comments?

18 (No response.)

19 CHAIRPERSON OLSON: Do any of our
20 ex officio members have anything to add to this?

21 MR. HAMMOUDEH: No. Thank you.

22 CHAIRPERSON OLSON: Okay. We're going
23 to need a motion here, and I don't have it -- I guess
24 the motion would be to grant Cook County Hospital a

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1 one-year --

2 MR. URSO: Temporary suspension.

3 MEMBER GALASSI: Temporary suspension.

4 CHAIRPERSON OLSON: -- temporary

5 suspension in their inpatient obstetrical and critical

6 care services at Provident Cook County Hospital --

7 MEMBER BRADLEY: I so move.

8 CHAIRPERSON OLSON: -- effective the --

9 MEMBER GALASSI: Second.

10 CHAIRPERSON OLSON: -- today. It would

11 be effective today.

12 I have a motion and a second.

13 MR. ROATE: One-year temporary

14 suspension; motion made by Justice Greiman; seconded

15 by Mr. Galassi.

16 MEMBER BRADLEY: Actually, it was me.

17 CHAIRPERSON OLSON: It was made by Phil.

18 MR. ROATE: I'm sorry. Made by

19 Mr. Bradley; seconded by Mr. Galassi.

20 Mr. Bradley.

21 MEMBER BRADLEY: Yes.

22 MR. ROATE: Justice Greiman.

23 MEMBER GREIMAN: I am going to vote yes

24 because of the change in how we -- the whole medical

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1 situation in America. We have new -- new issues that
2 we didn't have a couple years ago.

3 And so I'm going to vote yes, but I'm going
4 to tell you this: That if I'm on this Board next year
5 and you have the same motion, I'll vote no then, just
6 so you know.

7 MR. ROATE: Thank you.

8 Mr. Galassi.

9 MEMBER GALASSI: Yes, based on the
10 evolution of health care.

11 MR. ROATE: Mr. Hayes.

12 VICE CHAIRMAN HAYES: Yes, based on the
13 explanation that the -- that the Cook County Hospital
14 has provided.

15 MR. ROATE: Mr. Sewell.

16 MEMBER SEWELL: I'm going to abstain due
17 to a potential conflict of interest.

18 I'm a board member of Community Health, and
19 we've been talking with the County about becoming a
20 part of the network that Dr. Shannon presented.

21 MR. ROATE: Thank you, Mr. Sewell.

22 Madam Chair.

23 CHAIRPERSON OLSON: I vote no for
24 reasons stated previously.

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1 MR. ROATE: That's 4 votes in the
2 affirmative, 1 vote in the negative.

3 MEMBER SEWELL: And 1 abstention.

4 CHAIRPERSON OLSON: And 1 abstention.

5 MR. ROATE: And 1 abstention.

6 CHAIRPERSON OLSON: The motion does not
7 pass.

8 So what goes from here?

9 MR. URSO: I think that perhaps you
10 should have a meeting with staff for some technical
11 assistance at this point because one of the options
12 might be at this point in time you need to submit for
13 formal discontinuation of those services.

14 But I think we should have some discussions
15 about that so --

16 CHAIRPERSON OLSON: So do they have the
17 option of filing for reopening the service?

18 MR. URSO: They can. They can do that,
19 too, sure.

20 CHAIRPERSON OLSON: So work with the
21 State Board.

22 MEMBER BRADLEY: Madam Chair, is there
23 some way that this Board can postpone consideration of
24 this matter until the next meeting?

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1 CHAIRPERSON OLSON: We just voted.

2 MEMBER BRADLEY: I know. But I think
3 under Robert's Rules of Order --

4 MR. URSO: For reconsideration?

5 MEMBER BRADLEY: -- people -- someone
6 who voted in the affirmative can -- and let me restate
7 that.

8 I think it's possible to move for
9 reconsideration.

10 MEMBER GALASSI: And then you can define
11 does Member Sewell have a conflict or not.

12 MEMBER SEWELL: Because mine is only a
13 potential -- I haven't explored whether it's a real
14 conflict, but it is a potential conflict, so I'd
15 rather not vote yea or nay.

16 CHAIRPERSON OLSON: I have to defer to
17 legal counsel. I don't know.

18 (Discussion off the record.)

19 CHAIRPERSON OLSON: We're going to take
20 some time to research that possibility, and we will
21 let you know if we can bring it back for
22 reconsideration.

23 MEMBER BRADLEY: Or is it possible for
24 the maker of the motion to table it at this point?

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1 CHAIRPERSON OLSON: Once you've made --
2 I mean, the vote's been taken. I guess we can look
3 and see whether, based on Mr. Sewell's conflict of
4 interest . . .

5 MEMBER BRADLEY: What's the legislature
6 do, Judge?

7 MEMBER GREIMAN: I think that the motion
8 to reconsider would be an appropriate thing for us to
9 consider. And we could put that off for, you know, a
10 month to decide it. That's all.

11 MEMBER GALASSI: Our rules require
12 5 positive votes to pass. That's the dilemma we're in
13 right now.

14 MR. URSO: And once the motion comes
15 before the full body, it's no longer in control of the
16 maker. And so the motion was presented and the vote
17 was taken, so --

18 MEMBER GREIMAN: Well, somebody can move
19 for reconsideration.

20 MEMBER BRADLEY: Somebody can move for
21 reconsideration.

22 MR. URSO: Right. And that's what
23 we're -- we've established that we're going to
24 research that.

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1 MEMBER GREIMAN: That's what the
2 motion is.

3 MEMBER BRADLEY: So we're going to
4 research -- are you accepting a motion to reconsider?

5 If so --

6 MEMBER GREIMAN: No. He said he's going
7 to research that.

8 CHAIRPERSON OLSON: You're making a
9 motion to reconsider the motion?

10 MEMBER BRADLEY: Yes, at the next
11 meeting.

12 (Discussion off the record.)

13 CHAIRPERSON OLSON: So I guess we have a
14 motion to reconsider the decision.

15 Is there a second to that motion?

16 MEMBER GALASSI: Second.

17 CHAIRPERSON OLSON: Can I have a roll
18 call vote?

19 MR. ROATE: Yes, ma'am.

20 Who made the motion?

21 MEMBER BRADLEY: I did.

22 MR. ROATE: Mr. Bradley?

23 Motion made by Mr. Bradley; seconded by
24 Mr. Galassi.

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1 Mr. Bradley.

2 MEMBER BRADLEY: I do so in the hope
3 that a Board with a larger --

4 MEMBER GALASSI: Presence.

5 MEMBER BRADLEY: -- presence will take
6 this matter under advisement and consider a different
7 outcome so I vote yes.

8 MR. ROATE: Justice Greiman.

9 MEMBER GREIMAN: I -- with some concern
10 that this will be -- this will be the tactic that we
11 start now, I -- I'll vote yes but with great concern
12 over it.

13 MR. ROATE: Mr. Galassi.

14 MEMBER GALASSI: Yes.

15 MR. ROATE: Mr. Hayes.

16 VICE CHAIRMAN HAYES: Yes.

17 MR. ROATE: Mr. Sewell.

18 MEMBER SEWELL: Abstain due to a
19 potential conflict, board member of the Community
20 Health.

21 MR. ROATE: Thank you, sir.

22 Madam Chair.

23 CHAIRPERSON OLSON: And I vote no based
24 on the precedent that it sets for any other negative

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1 vote.

2 MR. ROATE: That's 4 votes in the
3 affirmative, 1 abstention, and 1 negative vote.

4 MEMBER GREIMAN: The question is whether
5 the motion to reconsider -- for us to consider it --
6 requires the -- just a majority of those voting --

7 MR. URSO: No.

8 MEMBER GREIMAN: -- or the majority
9 of six.

10 I don't know the answer to that.

11 MR. URSO: Any action items require
12 5 votes per the Board's statute.

13 MEMBER GALASSI: Well, that's a statute
14 we should try to change.

15 CHAIRPERSON OLSON: And we discussed
16 that.

17 MEMBER GREIMAN: Yeah.

18 CHAIRPERSON OLSON: The vote fails.
19 We will contact you about where we go from
20 here.

21 DR. SHANNON: Okay. Thank you.

22 CHAIRPERSON OLSON: Thank you.

23 The next order of business is the financial
24 report.

