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HEALTH FACILITIES &
SERVICES REVIEW BOARD

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

OPEN SESSION

JUNE 28, 2011

DAY 1

ORIGINAL

1 STATE OF ILLINOIS

2 HEALTH FACILITIES AND SERVICES REVIEW BOARD

3 525 West Jefferson Street, 2nd Floor

4 Springfield, Illinois 62761

5 217-782-3516

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8

9 OPEN SESSION

10 DAY 1

11 The regular session of the meeting of the State of

12 Illinois Health Facilities and Services Review Board was

13 held on June 28, 2011, at Holiday Inn Joliet Conference

14 Center, 411 South Larkin, Joliet, Illinois.

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1 PRESENT:

2 Dale Galassie - Chairman
Ronald Eaker
3 John Hayes
John Burden
4 Alan Greiman
Kathy Olson
5 Richard Sewell
Rob Hilgenbrink
6 David Penn

7 ALSO PRESENT:

8 Courtney Avery - Administrator
Cathy Clarke - Assistant
9 Frank Urso - Legal Counsel
10 Juan Morado
11 Michael Constantino - IDPH Staff
12 George Roate - IDPH Staff
13 Bill Dart - IDPH Staff
14 David Carvalho - Deputy Director, IDPH
15 Michael C. Jones - IDFS
16 Mike Pelletier - IDHS
17
18 Reported by:
19 Karen K. Keim
20 CRR, RPR, CSR-IL, CRR-MO
21 Midwest Litigation Services
22 711 North Eleventh Street
23 St. Louis, MO 63101
24 314.644.2191

1 START TIME: 9:30 a.m.

2

3 CHAIRMAN GALASSIE: Good morning. I'll call

4 the meeting to order. I apologize we're a few moments

5 late. I like to be on time. We do have a quorum, though

6 all of our members are not yet here, and anyone who drove

7 in on 80 knows why. But they are on their way and we're

8 told near Monee, so it shouldn't be too long.

9 We are -- despite the size of the crowd, after

10 we do a roll call, approval of the agenda, we are going to

11 take a brief 10 or 15-minute stretch, because we have new

12 members here and, really, the idea was to allow new members

13 to meet existing members. So, you will have a few-minute

14 stretch, if you so like. We would just like to have Board

15 members interact with each other briefly rather than just

16 jumping right into the meeting.

17 That having been said, Ms. Avery will do roll,

18 please.

19 MS. AVERY: Member Burden?

20 CHAIRMAN GALASSIE: On the way.

21 MS. AVERY: Member Eaker?

22 MR. EAKER: Present.

23 MS. AVERY: Member Greiman?

24 MR. GREIMAN: Here.

1 MS. AVERY: Member Hayes?

2 MR. HAYES: Here.

3 MS. AVERY: Member Hilgenbrink?

4 MR. HILGENBRINK: Here.

5 MS. AVERY: Member Olson?

6 MS. OLSON: Present.

7 MS. AVERY: Member Penn?

8 MR. PENN: Here.

9 MS. AVERY: Member Sewell?

10 MR. SEWELL: Present.

11 MS. AVERY: Member Galassie.

12 CHAIRMAN GALASSIE: Present.

13 MS. AVERY: We have a quorum.

14 CHAIRMAN GALASSIE: Thank you very much. And

15 can I have a roll call vote for approval of the agenda,

16 please?

17 MR. ROATE: Dr. Burden not present.

18 Mr. Eaker?

19 MR. EAKER: Yes.

20 MR. ROATE: Justice Greiman?

21 MR. GREIMAN: Yes.

22 MR. ROATE: Mr. Hayes?

23 MR. HAYES: Yes.

24 MR. ROATE: Mr. Hilgenbrink?

1 MR. HILGENBRINK: Yes.
2 MR. ROATE: Ms. Olson?
3 MS. OLSON: Yes.
4 MR. ROATE: Mr. Penn?
5 MR. PENN: Yes.
6 MR. ROATE: Mr. Sewell?
7 MR. SEWELL: Yes.
8 MR. ROATE: Chairman Galassie?
9 CHAIRMAN GALASSIE: Yes.
10 Thank you very much.
11 MR. ROATE: That's eight in the positive.
12 CHAIRMAN GALASSIE: Motion passes.
13 We are going to take a ten-minute stretch.
14 You are welcome to stay in the room. You are welcome to do
15 whatever it is you would like.
16 John, let's do a self introduction, please.
17 MR. HAYES: My name is John Hayes, and I'm a
18 member from Cook County, and I'm the Vice Chairman.
19 MR. EAKER: My name is Ron Eaker. I am a
20 member appointed last year from Urbana, consumer advocate
21 member.
22 MS. OLSON: My name is Kathy Olson. I live in
23 Rochelle, Illinois, new Board member.
24 CHAIRMAN GALASSIE: Welcome Kathy.

1 MR. SEWELL: Richard Sewell from Chicago, new
2 Board member.
3 CHAIRMAN GALASSIE: Welcome, Richard.
4 Dale Galassie, Chair.
5 MR. URSO: Frank Urso, Legal Counsel.
6 MR. HILGENBRINK: New Board member Rob
7 Hilgenbrink from Metro East St. Louis area.
8 MR. PENN: David Penn, Board member,
9 Bloomington, Illinois.
10 MR. GREIMAN: Alan Greiman, a Board member
11 from Cook County.
12 MR. CARVALHO: David Carvalho, ex-officio
13 Board member from the Illinois Department of Public Health.
14 MR. JONES: Mike Jones, ex-officio Board
15 member from the Illinois Department of Healthcare and
16 Family Services.
17 CHAIRMAN GALASSIE: And Courtney Avery, our
18 Administrator.
19 Again, we're going to take about a 10-minute
20 break for Board members to meet each other and to get the
21 sound system adjusted. It is about quarter to 10. We will
22 gather again at five to 11. Thank you.
23 (Recess)
24 CHAIRMAN GALASSIE: Thank you very much. We

1 appreciate your 10 minutes or so. We will reconvene. I am
2 going to ask for a approval of the minutes.
3 MR. HAYES: So moved.
4 MR. EAKER: Second.
5 CHAIRMAN GALASSIE: Motion and second for the
6 minutes. Recommended changes? Courtney has some from the
7 Chair.
8 MS. AVERY: Sorry. On page 75, lines 13 and
9 22, that should read "HC" instead of "AC". These are the
10 March meeting minutes. For March 21st, page 76, the same
11 error on line 5, should read "FQHC". Page 13 on the March
12 21st meeting, meeting minutes for Executive Session, on
13 page 13, line 15, should read 28 hundred dollars.
14 No corrections for the April and no
15 corrections for March 22nd.
16 For May 10th, throughout the meeting minutes
17 when Ms. Claire Burman is speaking, her name should be
18 spelled B-u-r-m-a-n instead of B-e-r-m-a-n.
19 CHAIRMAN GALASSIE: Thank you very much. I
20 believe I need a vote on the minutes.
21 MR. HAYES: So moved.
22 MR. EAKER: Second.
23 CHAIRMAN GALASSIE: Moved and seconded. All
24 in favor?

1 ("Ayes" heard)

2 CHAIRMAN GALASSIE: Voice vote. Thank you

3 very much. Motion passes. Mr. Constantino.

4 MR. CONSTANTINO: Yes, thank you,

5 Mr. Chairman.

6 These are items approved by the Chairman.

7 Permit number 08-097, Hickory Point Christian Village, to

8 establish a 47-bed long-term care facility. Permit renewed

9 from May 31st, 2011 to August 31st, 2011. Approved June

10 7th, 2011.

11 Permit number 09-055, Palos Park Dialysis to

12 establish a 12-bed End Stage Renal Dialysis facility.

13 Permit renewed from August 31st, 2011 to August 31st, 2012.

14 Approved June 17th, 2011.

15 Permit number 09-065, Northwestern Lake Forest

16 Hospital to establish Grayslake outpatient facility.

17 Permit renewed from June 30th, 2011 to October 31st, 2011.

18 Approved June 17th, 2011.

19 Thank you, Mr. Chairman.

20 CHAIRMAN GALASSIE: Thank you, Mike.

21 I'll need a motion and a second and a vote to

22 approve the recommendations by the Chair.

23 JUSTICE GREIMAN: Move.

24 MS. OLSON: Second.

1 CHAIRMAN GALASSIE: Moved and seconded. Roll
2 call, George?
3 MR. ROATE: Motion made by Justice Greiman,
4 seconded by Ms. Olson.
5 Dr. Burden is absent.
6 Mr. Eaker?
7 MR. EAKER: Yes.
8 MR. ROATE: Judge Greiman?
9 MR. GREIMAN: Yes.
10 MR. ROATE: Mr. Hayes?
11 MR. HAYES: Yes.
12 MR. ROATE: Mr. Hilgenbrink?
13 MR. HILGENBRINK: Yes.
14 MR. ROATE: Ms. Olson?
15 MS. OLSON: Yes.
16 MR. ROATE: Mr. Penn?
17 MR. PENN: Yes.
18 MR. ROATE: Mr. Sewell?
19 MR. SEWELL: Yes.
20 MR. ROATE: Chairman Galassie?
21 CHAIRMAN GALASSIE: Yes.
22 MR. ROATE: That's eight votes in the
23 positive.
24 CHAIRMAN GALASSIE: Motion passes. Thank you

1 very much.

2 Moving on to Item No. 6, Procedures for Public

3 Comment. Mr. Urso?

4 MR. URSO: Thank you, Mr. Chair.

5 The Open Meetings Act requires that any person

6 shall be permitted an opportunity to address public

7 officials under the rules established and recorded by the

8 public body. The following is the procedure which the

9 Illinois Health Facilities and Services Review Board will

10 adhere to:

11 Number one: So that the Board is able to

12 accomplish other agenda items, there will be two minutes

13 allotted to provide public comments. Please understand,

14 when the Chairman signals, you must conclude your comments.

15 Number two: The Board asks that you please

16 make sure that all comments are relevant to the specific

17 projects on the Board's agenda and are not repetitive and

18 not disruptive to today's Board proceedings. Anyone who

19 wishes to provide public comment can see Mrs. Clarke, the

20 lady over on my left, or Courtney Avery, who is the

21 Administrator of the Board. Please note, if you have

22 previously participated in any public hearings of the Board

23 or submitted written comments to the Board related to

24 projects listed on today's agenda, it is not necessary, not

1 necessary to repeat your previous comments, because each
2 Board member has that material available. So, if you've
3 previously spoken at a public hearing or submitted written
4 comments to the Board, the Board members already have that
5 material. It is not necessary to repeat that information.
6 Thank you.
7 CHAIRMAN GALASSIE: Thank you, Frank.
8 In full disclosure, we encourage anyone that
9 wants to make comments to be respectful of the time and of
10 one another. If you haven't already signed up, please do
11 so, so we have a sense this morning of how many people are
12 speaking for flow purposes.
13 Moving on to Item No. 7, Items for State Board
14 Action. There are four such items and each will require
15 individual motion.
16 I'm looking at number 05-002, Clare Oaks. Can
17 I have a motion to approve the permit renewal for permit
18 05-002, Clare Oaks.
19 MR. HAYES: So moved.
20 MR. GREIMAN: Second.
21 CHAIRMAN GALASSIE: Moved and seconded. Roll
22 call vote?
23 MR. ROATE: Motion made by Mr. Hayes, seconded
24 by Justice Greiman. Call for a vote. Dr. Burden is

1 absent.

2 Mr. Eaker?

3 MR. EAKER: Yes.

4 MR. ROATE: Judge Greiman?

5 MR. GREIMAN: Yes.

6 MR. ROATE: Mr. Hayes?

7 MR. HAYES: Yes.

8 MR. ROATE: Mr. Hilgenbrink?

9 MR. HILGENBRINK: Yes.

10 MR. ROATE: Ms. Olson?

11 MS. OLSON: Yes.

12 MR. ROATE: Mr. Penn?

13 MR. PENN: Yes.

14 MR. ROATE: Mr. Sewell?

15 MR. SEWELL: Yes.

16 MR. ROATE: Chairman Galassie?

17 CHAIRMAN GALASSIE: Yes.

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

19 affirmative.

20 CHAIRMAN GALASSIE: Motion passes. And just

21 to remind new Board members, these are permit renewal

22 requests. If there are questions, please ask.

23 I'd like a motion to renew permit number

24 07-090, Southwestern Medical Center.

1 MS. OLSON: So moved.
2 MR. HILGENBRINK: Seconded.
3 CHAIRMAN GALASSIE: Moved and seconded.
4 MR. GREIMAN: I question if the time we're
5 allowing here is enough or whether they're likely to be
6 back in a few days. It's a big project, and it seems to me
7 that -- you know, I wouldn't like to see them back again.
8 CHAIRMAN GALASSIE: Southwestern
9 specifically?
10 MR. GREIMAN: Yeah.
11 CHAIRMAN GALASSIE: George, do you want to
12 comment, or Michael?
13 MR. ROATE: The permit renewal itself they're
14 asking to extend to September 30th. The project -- the
15 construction phase itself is complete. It is my
16 understanding that the only item waiting -- they're
17 currently waiting for the inspection from the Illinois
18 Department of Public Health, which could occur usually in
19 the next two to three month time period.
20 MR. GREIMAN: So the construction itself is
21 complete?
22 MR. ROATE: The project itself is complete.
23 MR. GREIMAN: Okay. That's fine.
24 MR. CONSTANTINO: Mr. Chairman?

1 CHAIRMAN GALASSIE: Sir.

2 MR. CONSTANTINO: Friday I was notified that

3 the inspection did take place by IDPH. So now we're

4 waiting for information from Karen Singer and the license.

5 So, we expect the project to be completed within the

6 required time frames they're requesting here.

7 CHAIRMAN GALASSIE: Great. Thank you.

8 Do I have a motion and a second?

9 MS. OLSON: So moved.

10 MR. SEWELL: Second.

11 CHAIRMAN GALASSIE: Roll call?

12 MR. ROATE: Motion made by Ms. Olson, seconded

13 by Mr. Sewell.

14 Dr. Burden is absent.

15 Mr. Eaker?

16 MR. EAKER: Yes.

17 MR. ROATE: Judge Greiman?

18 MR. GREIMAN: Yes.

19 MR. ROATE: Mr. Hayes?

20 MR. HAYES: Yes.

21 MR. ROATE: Mr. Hilgenbrink?

22 MR. HILGENBRINK: Yes.

23 MR. ROATE: Ms. Olson?

24 MS. OLSON: Yes.

1 MR. ROATE: Mr. Penn?
2 MR. PENN: Yes.
3 MR. ROATE: Mr. Sewell?
4 MR. SEWELL: Yes.
5 MR. ROATE: Chairman Galassie?
6 CHAIRMAN GALASSIE: Yes.
7 MR. ROATE: That's eight votes in the
8 positive.
9 CHAIRMAN GALASSIE: Thank you very much.
10 Motion passes.
11 Moving on to Item A-3, 09-029 Monroe County
12 Surgical Center. I would entertain a motion to approve the
13 permit renewal for Permit 09-029, Monroe County Surgical
14 Center.
15 MR. HILGENBRINK: Move to approve.
16 CHAIRMAN GALASSIE: Motion to approve. Can I
17 get a second?
18 MR. HAYES: Second.
19 CHAIRMAN GALASSIE: Motion and a second. Any
20 questions?
21 MS. OLSON: One question, just on the letter
22 dated May 16th to Ms. Avery, it says the reason for this
23 request is licensure delays. Does that refer to untimely
24 filing or compliance issues or waiting to get the --

1 MR. CONSTANTINO: Generally the Department has
2 a backlog of these surveys.
3 MS. OLSON: Okay. Thank you.
4 CHAIRMAN GALASSIE: Any other questions?
5 (Pause)
6 CHAIRMAN GALASSIE: Hearing none, roll call
7 vote, please.
8 MR. ROATE: Motion made by Mr. Hilgenbrink,
9 seconded by Mr. Hayes.
10 Dr. Burden is absent.
11 Mr. Eaker?
12 MR. EAKER: Yes.
13 MR. ROATE: Judge Greiman?
14 MR. GREIMAN: Yes.
15 MR. ROATE: Mr. Hayes?
16 MR. HAYES: Yes.
17 MR. ROATE: Mr. Hilgenbrink?
18 MR. HILGENBRINK: Yes.
19 MR. ROATE: Ms. Olson?
20 MS. OLSON: Yes.
21 MR. ROATE: Mr. Penn?
22 MR. PENN: Yes.
23 MR. ROATE: Mr. Sewell?
24 MR. SEWELL: Yes.

1 MR. ROATE: Chairman Galassie?
2 CHAIRMAN GALASSIE: Yes.
3 MR. ROATE: That's eight votes in the
4 positive.
5 CHAIRMAN GALASSIE: Motion passes. Moving on
6 to Item No. 7, A-4, Fresenius Medical Care, Elgin. I would
7 entertain a motion to approve the permit renewal for Permit
8 08-104, Fresenius Medical Care, Elgin. Can I get a motion
9 to approve that?
10 MS. OLSON: So moved.
11 CHAIRMAN GALASSIE: So moved.
12 MR. HAYES: Second.
13 CHAIRMAN GALASSIE: Questions regarding this
14 item?
15 (Pause)
16 CHAIRMAN GALASSIE: Hearing none, roll call,
17 please.
18 MR. ROATE: Motion made by Ms. Olson, seconded
19 by Mr. Hayes.
20 Dr. Burden is absent.
21 Mr. Eaker?
22 MR. EAKER: Yes.
23 MR. ROATE: Judge Greiman?
24 MR. GREIMAN: Yes.

1 MR. ROATE: Mr. Hayes?
2 MR. HAYES: Yes.
3 MR. ROATE: Mr. Hilgenbrink?
4 MR. HILGENBRINK: Yes.
5 MR. ROATE: Ms. Olson?
6 MS. OLSON: Yes.
7 MR. ROATE: Mr. Penn?
8 MR. PENN: Yes.
9 MR. ROATE: Mr. Sewell?
10 MR. SEWELL: Yes.
11 MR. ROATE: Chairman Galassie?
12 CHAIRMAN GALASSIE: Yes.
13 MR. ROATE: That's eight votes in the
14 affirmative.
15 CHAIRMAN GALASSIE: Motion passes. Thank you
16 very much.
17 Moving on, Extension Requests, we have none.
18 Exemption requests. We have one. Is there
19 anyone here who wants to comment on Exemption 001-011,
20 Surgery Center of Southern Illinois.
21 MS. AVERY: Yes, Mr. Chair, we have Mark
22 Silberman. After Mark Silberman will be Aaron Luther.
23 Mr. Silberman?
24 (Pause)

1 CHAIRMAN GALASSIE: And while they're coming
2 in to be sworn in and introduce themselves, I apologize we
3 cannot call for anymore chairs in the room, because we are
4 at the fire capacity. So we regret that some of you are
5 standing seats only, but I expect we will be having some
6 turnover, so you won't be standing all day.
7 Would you please introduce yourself and be
8 sworn in. Thank you very much.
9 MR. SILBERMAN: Absolutely. My name is Mark
10 Silberman.
11 (Oath given)
12 CHAIRMAN GALASSIE: Proceed.
13 MR. SILBERMAN: We'd like to thank the Board
14 for the opportunity to present this comment, and we
15 certainly want to commend the Staff for putting together a
16 very difficult State Agency Report. Never has there been
17 this level of opposition to a change of ownership. A few
18 points got lost in the processing and in trying to
19 summarize over 2000 letters of opposition with regards to
20 this change of ownership. Therefore we have three brief
21 but important points in response to the State Agency Report
22 that we wanted to present to the Board.
23 The first is on page 5 of the State Agency
24 Report. It incorrectly states that there were eleven

1 individuals in opposition at the public hearing. The Board
2 Staff did prepare an amended report, and the supporting
3 documentation from the public hearing clearly reflect that
4 of the 264 individuals who registered their attendance at
5 the public hearing, 223 of those people attended and
6 registered their opposition in writing, with another eleven
7 individuals who spoke in opposition. And, therefore,
8 234 -- or 89 percent of the 264 individuals -- at that
9 public hearing registered their opposition to this project.
10 The second is the State Agency Report presents
11 the claim that this application meets the requirements that
12 no surgery specialties will substantially change. However,
13 it's important to point out that nowhere does the State
14 Agency Report reflect, and we think the Board needs to
15 know, that the Marion Eye Centers, the physician group
16 performing almost all of the ophthalmological services, has
17 made it clear they will not continue to perform procedures
18 at the surgery center if the CO is approved. This is
19 important because by the Board's own statistics, this group
20 is providing 85 to 97 percent of the historical procedures,
21 of all procedures, at this facility and, therefore, it's
22 unclear how this applicant can claim or how the Staff
23 concluded that there will be no changes to the scope and
24 level of services.

1 The third point is the summarization that the
2 State Agency Report -- they summarize the opposition as
3 focusing on the fact that Mr. Osman is not a physician and
4 focusing on multiple allegations of unethical dealings.
5 Now, it is true in the comments that there was a journalist
6 who did raise some concerns with regards to Mr. Osman's
7 ownership of land related to a TIF district, and I will
8 acknowledge that we did raise an issue with regards to the
9 corporate practice of medicine.
10 CHAIRMAN GALASSIE: Thirty seconds,
11 Mr. Silberman.
12 MR. SILBERMAN: No problem. Thank you, sir.
13 However, the core issue which is not reflected in this
14 State Agency Report is reflected by the voices of over 2000
15 members of the public, and the real issue that we hope this
16 Board will focus on is the individual consumers of
17 healthcare have presented the following question: If this
18 Board approves this change of ownership, is access to
19 healthcare in Marion going to be improved or harmed? Will
20 it be better today than it is tomorrow? We believe the
21 answer is no, which is why we have presented the opposition
22 that we have.
23 As a final matter, we would simply add, if it
24 does turn out the Board members have any questions of the

1 opposition or any of the information we've provided, we
2 would just point out we are here and available to address
3 any concerns the Board would have.
4 Thank you.
5 CHAIRMAN GALASSIE: Thank you very much.
6 Again, we appreciate your being reasonably concise where
7 possible and ask that you try to stick to a two-minute
8 rule, if prepared to do so.
9 Anyone else to speak to this issue.
10 Thank you very much. If you would introduce
11 yourself and be sworn in.
12 MR. LUTHER: My name is Aaron Luther.
13 MS. AVERY: Following Mr. Luther is John
14 Womick.
15 MR. LUTHER: Good morning. My name is Aaron
16 Luther. I'm a Vice-President of Operations for Surgical
17 Care Affiliates. I have overseen the operations of the
18 Surgery Center of Southern Illinois for the last two and a
19 half years. I'm here to express my support for the change
20 of ownership of the Surgery Center of Southern Illinois and
21 to clarify the record a bit.
22 I'd like to respond to a recent comment
23 regarding Ron Osman's intent to purchase the Surgery Center
24 of Southern Illinois. It was never our company's

1 understanding that Mr. Osman intended to close the surgery
2 center, and then having reviewed our counsel's version of
3 his discussions of this transaction, no such intent was
4 ever expressed to him by Mr. Osman.
5 I'd also like to take this opportunity to
6 clarify some issues raised in the opposition comments
7 regarding the sale of SCA's interests in the surgery center
8 of Illinois. In 2007 SCA purchased a controlling interest
9 in the surgery center from Health South. In March 2007,
10 Dr. Ahmad, through a wholly-owned company, filed an
11 application for a new surgery center in Mt. Vernon, which
12 was approved by the Health Facilities Planning Board in
13 January 2008. In April 2010, Dr. Ahmad opened Mt. Vernon
14 Eye Center and immediately began to divert cases from the
15 Surgery Center of Southern Illinois. In fact, Dr. Ahmad
16 and his colleagues routinely provide free transportation
17 from Marion to Mt. Vernon Eye Center to facilitate the
18 referral of patients. As a result of this coordinated
19 effort, surgeries performed at the Surgery Center of
20 Southern Illinois fell by over 90 percent in the twelve
21 months following the opening of the Mt. Vernon Eye Center,
22 from 3,114 procedures for the twelve-month period ending 31
23 March 2010 to 276 procedures for the twelve-month period
24 ending 31 March 2011. It's apparent Dr. Ahmad and his

1 colleagues engaged in conduct in this diversion from
2 Surgery Center of Southern Illinois to Mt. Vernon Eye
3 Center to not only profit Mt. Vernon Eye Center but also to
4 force the sale of SCA's controlling interest in Surgery
5 Center of Southern Illinois to Dr. Ahmad.
6 Mr. Osman has experience managing surgery
7 centers and, in fact, is one of the founding members of
8 this particular surgery center. In all of my dealings with
9 Mr. Osman, his primary concern has always been the
10 operation and continued viability of the Surgery Center of
11 Southern Illinois.
12 Finally, I'd like to note that those opposing
13 this application have consistently praised the clinical
14 staff of the Surgery Center of Southern Illinois. It is my
15 understanding that Mr. Osman is committed to preserving the
16 clinical staff, to ensure high quality healthcare is
17 available to the residents of Marion.
18 Thank you for your time and attention. I
19 respectfully request this Board approve the change of
20 ownership of the Surgery Center of Southern Illinois.
21 CHAIRMAN GALASSIE: Thank you, Mr. Luther.
22 MR. GREIMAN: I have a question for you. I
23 want to know -- our records indicate --
24 CHAIRMAN GALASSIE: Judge, is this question

1 for Mr. Luther?

2 MR. GREIMAN: Yes. Our records indicate that

3 the value of the center in 1985 -- I'm sorry, in 2007 was

4 $8,808,000. That was its value. Sixty percent of it is

5 being sold for $1,512,000. Is that because of competition

6 or what? Why is that?

7 MR. LUTHER: It's a direct reflection on the

8 deterioration of revenue and profitability that I

9 referenced, related to the case volume decreases.

10 MR. GREIMAN: So that's what it would be?

11 That's what it was? It was worth eight million five, now

12 it's worth about two million?

13 MR. LUTHER: That's correct.

14 CHAIRMAN GALASSIE: Thank you. We have one

15 more public comment, and then the applicant will come

16 before us.

17 (Oath given)

18 MR. WOMICK: My name is John Womick. I'm an

19 attorney from Carbondale, Illinois. I represent Dr. Ahmad.

20 There are lots of people here today. Would

21 people here in opposition please stand quickly.

22 (Pause)

23 MR. WOMICK: Thank you. You can sit down.

24 (Pause)

1 MR. WOMICK: The issue here is -- you've heard
2 a lot and you've read a lot about Osman and Ahmad. They
3 don't like each other. Osman is not going to work with
4 Ahmad. That's an absolute, total fact. Why this agency or
5 entity would sell to somebody they know Ahmad would not
6 work with shows bad management on their part.
7 But the issue you have to concern yourself
8 with is healthcare and access to healthcare. I have in
9 front of me a letter from Kayla Martin, 86-year-old woman
10 from Benton, that she sent to you. Says in part, "Why make
11 it hard on doctors, staff, patients, family to travel so
12 far? Open your eyes and see what you are doing and taking
13 away. Open your ears and listen to what we have to say."
14 And then she closes by saying, "Please hear me". And those
15 are the people for whom I speak.
16 Do you understand that a vote in favor of this
17 transfer is a vote against access to ophthalmological care,
18 to cataract surgery for the senior citizens of Illinois?
19 Do you understand that? That's exactly what you're talking
20 about today. You heard this man just speak about 90
21 percent is gone, and that's a fact. 90 percent is gone.
22 Osman and Ahmad aren't going to work together, you can bet
23 on that. So your question is, you don't have to end the
24 fight on one side or the other. You have to end the fight

1 on behalf of access to healthcare for senior citizens at a
2 time they're being told they're not entitled to Social
3 Security, where they're concerned about their healthcare.
4 This agency today has to decide, are you taking away their
5 healthcare.
6 Ron Osman is a good lawyer. He has yet to do
7 cataract surgery. He can't do it. 3,300 of the cataract
8 surgeries done at this facility last year, done by Ahmad's
9 group, they are gone. How in the hell are you going to
10 replace them? How can you honestly say that a vote in
11 favor of this provides access to healthcare? The answer is
12 you cannot.
13 Thank you.
14 CHAIRMAN GALASSIE: Thank you.
15 MS. AVERY: Carolyn Swartos, and following her
16 is Dan Whitfield.
17 MR. URSO: Anyone who comes to speak to the
18 Board, please sign the pad of paper that's at the
19 microphone.
20 (Oath given)
21 MS. SWARTOS: My name is Carolyn Swartos. I'm
22 the reporter that submitted the packet regarding the TIF
23 information and the ownership of property. The reason I
24 was coming today was after the deadline, there was a letter

1 written by the City Administrator, Gale West, that stated
2 that Mr. Osman didn't have any information regarding the
3 TIF move of his properties. My only contention to Miss
4 West's comments -- again, past the deadline -- is that
5 according to City Ordinances 2314, 2315 and 2316, the
6 property owners were notified February 26, 2010, a year in
7 advance of this purchase, intended purchase, were informed
8 of the move of those properties into that TIF district. So
9 my contention is to rebut Miss West, and that is that the
10 property owners, including 40 properties, were moved into
11 the TIF, all excluding the surgery center. The surgery
12 center was not notified of the TIF move because of them
13 being the only property excluded out of the 40 properties,
14 and that was my comment today.
15 Thank you.
16 MR. SEWELL: I need for you to sort of explain
17 the significance of the -- this Tax Increment Financing
18 district?
19 MS. SWARTOS: Right.
20 MR. SEWELL: The significance of this to the
21 project. I understand everything you said, but I guess I
22 need the punch line about this. Is this to correct the
23 record?
24 MS. SWARTOS: I think the key thing is if you

1 look at a TIF -- the HUD TIF map and it's all the gray.
2 Okay? It was in the parcel you got from us. You can see
3 the orange is at the center of this thing, is where the
4 surgery center is being excluded. Of everything to be
5 developed in that region, the surgery center is in the way,
6 because it's in the middle of a whole section of land that
7 could be developed in the future. So that's the
8 significance, is that the exclusion of it is the
9 significant point.
10 CHAIRMAN GALASSIE: Thank you. Appreciate
11 that.
12 We have one more public comment.
13 MS. AVERY: Dan Whitfield.
14 CHAIRMAN GALASSIE: One more public comment
15 and then we'll move to the applicant, and if we can,
16 perhaps, hold our questions for the applicant, would be
17 most effective here.
18 (Pause)
19 CHAIRMAN GALASSIE: If you could introduce
20 yourself.
21 MR. WHITFIELD: My name is Dan Whitfield.
22 (Oath given)
23 MR. WHITFIELD: Good morning. I speak this
24 morning as a resident of southern Illinois, as a patient of

1 Dr. Ahmad's, and as a pastor. I did speak at the hearing
2 in Marion, and I spoke to the willingness and, indeed,
3 practice of Dr. Ahmad to accept patients living at the
4 poverty level who could not afford eye care. I spoke to
5 about -- I spoke about his standing in the community. What
6 I omitted and should have said was that when Dr. Ahmad came
7 to southern Illinois in 1978, there was one ophthalmologist
8 in all of southern Illinois. Almost everybody, therefore,
9 had to go to Chicago or St. Louis for eye care. Today,
10 thanks to the vision of Dr. Ahmad, there are Marion Eye
11 Centers all over southern Illinois, providing eye care for
12 the rural residents of southern Illinois. The impact that
13 the Marion Eye Center and Dr. Ahmad in particular has had
14 on the availability and accessibility and affordability of
15 eye care in southern Illinois is staggering. I don't have
16 data to back that up, but I'm sure that's available to this
17 group. But I want to emphasize the impact that that has
18 had on southern Illinois.
19 Thank you.
20 CHAIRMAN GALASSIE: Thank you very much.
21 Now I believe we have the applicants coming
22 forward. Kindly introduce yourself and be sworn in as
23 well.
24 MR. OSMAN: Ron Osman.

1 MS. FRIEDMAN: Kara Friedman.
2 MS. COOPER: Anne Cooper.
3 (Oath given).
4 CHAIRMAN GALASSIE: Thank you. Mike, did you
5 want to give us the background.
6 MR. CONSTANTINO: Thank you, Mr. Chairman.
7 The applicant is proposing a change of control
8 of a multi-specialty ASTC known as Surgery Center of
9 Southern Illinois. This surgery center is located in
10 Marion, Illinois. This is being done by the purchase of
11 100 percent interest in Marion Holding, LLC, which
12 currently owns 51 general partnership interests and 9.6
13 limited partnership interests. The cost of the project is
14 approximately $1.5 million.
15 The project is before the State Board because
16 the applicant is proposing a change of a control of a
17 healthcare facility. A public hearing was held on this
18 project on April 5th, 2011. 281 individuals were in
19 attendance. 6 individuals testified in support of the
20 project and 11 individuals testified in opposition. The
21 State Agency has received approximately 115 letters of
22 support and approximately 1,600 letters of opposition to
23 this project.
24 I would like to note an exemption for a change

1 of ownership means the applicant is exempt from the need
2 requirements of the Act. In an exemption, the applicant
3 must provide documentation that the State Board requires.
4 If that is done, the applicant has met the requirements of
5 the exemption, and, in this case, they have done that. I
6 would also like to note that as part of that requirement,
7 the applicants have attested that they will maintain
8 ownership of this facility for three years.
9 Thank you, Mr. Chairman.
10 CHAIRMAN GALASSIE: Thank you, Mike.
11 And for new members -- I'm sorry. We
12 typically have staff report and then we go to the
13 applicants themselves.
14 MS. FRIEDMAN: Good morning. I'm Kara
15 Friedman. I'm representing the applicant. I have with me
16 today Ron Osman who is the principle in the application.
17 To my left is Anne Cooper, also representing the applicant.
18 I appreciate Mike's introduction to this
19 project. I think that he has hit on all of the important
20 points about the procedure. I do believe that Mr. Osman
21 would like to address a couple of the points that were just
22 made, although I do believe that he has addressed all of
23 these concerns in the written materials, and I trust you've
24 had an opportunity to review those as well, but since

1 they've been raised at this moment, let's just take a
2 moment to review a few of those.
3 MR. OSMAN: Thank you. Appreciate the
4 opportunity to speak to the Board. I won't rehash the
5 application and all of the letters of support nor the
6 letters of opposition. I will make just a few points.
7 First, as Kara has indicated, I as a
8 co-applicant and Cirurgia Centro, LLC meets the
9 requirements for an exemption. There is not an issue of
10 the need. But I think it is important that we look at the
11 timeline just a little bit to emphasize that.
12 In April of 2010, the surgery center was -- it
13 has two OR rooms, and it was completely full. The
14 opposition is correct, Dr. Ahmad and his group were doing
15 85 to 95 percent of the surgeries at that time. Dr. Ahmad
16 received a Certificate of Need from this Board, and in the
17 first part of May, he completed his Illinois Department of
18 Public Health investigation and began to do surgeries in
19 Mt. Vernon. At that time, he canceled 24 surgeries at the
20 Marion Surgery Center, and he pulled -- contrary to what he
21 told this Board in 2007 when he had an Intent to Deny, he
22 told this Board that there would only be 748 cases that
23 would come out of the Marion service area and that would be
24 in the northern part of the service area. He then

1 voluntarily pulled all of his cases and took them to Mt.
2 Vernon and in many cases provided transportation.
3 I did not become involved in the attempt to
4 purchase this until December of 2010. So, the attack to me
5 personally, professionally, and the opposition letters is
6 nothing, as attorneys would say, but a red herring. For
7 those of you who are not attorneys, it's a diversion.
8 Dr. Ahmad voluntarily -- and the people that are here today
9 supporting him need to know, he voluntarily quit using the
10 Surgery Center of Southern Illinois in an attempt to drive
11 the price into the ground, and as the Justice has pointed
12 out, he did exactly that. He drove it from 8.8 million to
13 2 1/2 million, and I bought it, and he's upset over that,
14 and now he's trying to stop the exemption, because he
15 believes that he will then come in and purchase it, and
16 although he has no contract to purchase it, he believes
17 that that is what will happen.
18 It's also important to note that Dr. Ahmad and
19 his surgeons have surgical privileges at three hospitals in
20 southern Illinois and one competing surgery center that's
21 not a mile and a half down the street. There's absolutely
22 no reason for his patients to be traveling to Mt. Vernon
23 when he has surgical privileges at those facilities. So,
24 when you boil this all down, it's not about access to

1 healthcare. There's plenty of access to healthcare in
2 southern Illinois. It's not about access to healthcare.
3 We have surgery centers, we have hospitals. It's about one
4 man and one group wanting to purchase this facility and
5 getting his nose out of joint because somebody purchased it
6 and was willing to pay more.
7 Now, in regards to the letters of
8 opposition -- and this is in the material -- you will see
9 that Dr. Ahmad has sent out letters to all of his patients,
10 we estimate 40,000 letters, and those letters basically say
11 "If Mr. Osman, who is not our friend, and Mr. Osman's
12 unethical" -- now, there's nothing anybody likes to do
13 better than call an attorney unethical. I would submit we
14 can get anybody to sign anything if you say an attorney is
15 unethical. But whenever they receive a letter that says
16 that their doctor can no longer do surgery in Marion,
17 Illinois because of this unethical lawyer getting it, they
18 certainly will rightfully get upset, and I understand that.
19 Now, we intend to and will maintain the
20 services, the ophthalmological services. Dr. Ahmad is
21 correct, Mr. Womick is correct. They pull their cases.
22 Right now they're doing 6 percent in the last year. I have
23 the Administrator of the Surgery Center here. She's been
24 there over 10 years. The surgery center this month will do

1 161 surgeries. So, the surgery center will continue to
2 operate. We have ophthalmologists coming back on staff,
3 OB/GYN'S. It will continue to operate.
4 Now, you saw an example today of why
5 Mr. Womick is the premiere personal injury attorney in
6 southern Illinois. He gives an impassioned plea, and he
7 puts it to you to put it onto your shoulders, that if you
8 let this Ron Osman have the surgery center, you're going to
9 deny access. That's the reason he's good. But it's also
10 another diversion. It means nothing. There will not be
11 anybody denied access. It will be the same.
12 Now, in regards to Carolyn Swartos, I'm going
13 to finish with this, because that's the silliest thing to
14 come out of a whole host of silliness. The surgery center
15 is not in the TIF because it is not eligible. Mr. Sewell,
16 I think from your comments you may be aware of TIF. The
17 property has to be -- it has to be in a state of disrepair.
18 It has to be something that's not developed. The surgery
19 center is developed. That's the reason it wasn't put into
20 the TIF. It was not eligible. I personally did not have
21 any knowledge of my property being put in the TIF. I got
22 the notice like everyone else. I'm happy it is, and, in
23 fact, as we speak, there is an architect drawing plans for
24 four lots that I own for medical office buildings to

1 support the surgery center. Again, it has nothing to do
2 with my exemption, but the truth is that it will enhance
3 the project, because I intend to put in surgery -- suites
4 for doctors so it's more convenient for them.
5 So, in conclusion, I'm excited about once
6 again becoming involved in this particular service center.
7 I've been involved in healthcare all my life. I'm involved
8 in two public companies that develop biotech drugs, and I
9 look forward to continuing the excellent service that this
10 surgery center has been providing since it was formed in
11 1986.
12 Thank you.
13 CHAIRMAN GALASSIE: Questions from the Board.
14 Mr. Osman, are there multiple FQHC's that
15 refer to you?
16 MR. OSMAN: We don't have a lot of referral
17 for Qualified Health Centers, no.
18 CHAIRMAN GALASSIE: Thank you.
19 MR. PENN: Reading this summary of support and
20 opposition comments, this is pretty strong language, that
21 those proposing to purchase this ASTC are not physicians
22 and have unethical dealings with the surgical center in the
23 past. Can you comment on that?
24 MR. OSMAN: Sure. I'd be glad to. The --

1 first the issue of non-physicians. There is 40 ASTC's that
2 this group has licensed that has non-physicians in
3 ownership. We've done a survey of that. So this is
4 nothing new and, in fact, the Federal government and the
5 State government frowns upon physician ownership because of
6 the potential of fraud and abuse, and those of you that
7 know the system know that in order for a physician to have
8 ownership in a surgery center, there's a rigorous criteria
9 that you have to meet. So that is a real red herring.
10 There is absolutely no issue with that.
11 In regards to the unethical charge, several
12 years ago, I represented a doctor by the name of Dennis
13 Ryll, R-y-l-l, and Dr. Ahmad was waiving the copayment,
14 various different things, and Dr. Ryll went to work for
15 him, and he came to me, and I represented him in a false
16 claims action. I had earlier represented Dr. Ahmad in an
17 unassociated project. Several years went by when I brought
18 the false claims action. Dr. Ahmad's counsel, after we --
19 after the Answer, after we got into litigation, raised the
20 issue of whether or not that I could not represent him
21 because I had represented him previously. Judge Foreman,
22 the Southern District, had a hearing on that.
23 Now, it's been presented at the hearing, it's
24 been presented all along, that I was found of unethical

1 conduct. If you read the opinion -- and those of you that
2 are associated with the law -- you will see a very reasoned
3 opinion that says this is an extremely close call. Keep in
4 mind, Dr. Ahmad's testimony in that case and my testimony
5 was completely opposite. So, his memory of what was said,
6 his memory of what was done was completely opposite. But
7 the judge said that, you know, there is an appearance of
8 impropriety, so he removed me from the case. But he made a
9 specific finding that I was not guilty of any unethical --
10 he didn't use the words, but he didn't report me to the
11 ARDC and, in fact, I tried multi-million dollar cases after
12 that in front of Judge Foreman, the Blue Cross/Blue Shield,
13 144 million. I even personally represented Judge Foreman
14 after he retired.
15 So, to call me unethical based upon a removal
16 of an attorney for a conflict of interest that happens
17 every day in the legal profession -- and if you then will
18 read the letters of support from my business partners and
19 those that know me and those that I haven't sued --
20 obviously, if you sue somebody, they're not very happy with
21 you. And so that's the genesis of the charge that has been
22 thrown around very loosely and very inappropriately, in my
23 opinion. But I would rest upon my reputation with my
24 business partners, my reputation in the community for

1 ethics and not based upon that one decision.
2 Thank you.
3 MR. PENN: Comment. It's clearly indicating
4 there's more than one unethical dealing.
5 MR. OSMAN: Someone can accuse anything. I
6 have no idea what they're talking about. That's the only
7 thing that has been presented anywhere that I'm aware of.
8 MR. PENN: Thank you.
9 CHAIRMAN GALASSIE: Reporter, would you let
10 the record show that Dr. Burden is present?
11 MR. BURDEN: Thank you. I apologize to all
12 concerned.
13 I'm a retired urologist, and for 15 years I
14 sat on the Illinois State Medical Insurance Committee and
15 looked at all of the alleged malpractice in the state of
16 Illinois, and your name came across once. I got a good
17 memory. I have a son who does med mal defense work, and
18 I've heard a lot of names, and that's got nothing to do
19 with my feeling about your application. I just happen to
20 ask, is Madison County further south from where you reside?
21 MR. OSMAN: No. Madison County is north and
22 west of where we are. I've never had a case in Madison
23 County.
24 MR. BURDEN: Well, my son won a case, the

1 first case in 10 years in Madison County -- I thought it
2 would be interesting to point out that that area has had a
3 reputation, and I can speak to it, of being very successful
4 for Plaintiff's attorneys, lawyers, and that's got, again,
5 nothing to do, just a little background that my background
6 is diverse.
7 Coming back to the point, about 86 percent of
8 the cases done in this center are ophthalmological. Who is
9 the ophthalmologist that is doing all of the work in your
10 clinic that you're proposing to purchase?
11 MR. OSMAN: Well, first, what I'm purchasing
12 is a surgery center, not a clinic. So, the surgery center
13 does not hire ophthalmologists. At the time -- and the
14 numbers you're seeing is the ophthalmologists that were
15 doing the work, was Dr. Ahmad and his group. Now then we
16 have a young man by the name of Shawn Parker that comes in,
17 and he is increasing his presence in southern Illinois and,
18 quite frankly, he's able to increase his presence now
19 because Dr. Ahmad has determined that he's not going to do
20 surgery there anymore and so there is surgical space
21 available.
22 We also are increasing our ENT work. We're
23 looking at orthopedics. So we're increasing. Now, as I
24 indicated earlier, they are going to do 161 surgeries this

1 month and, quite frankly, you know, Dr. Ahmad has contacted
2 every doctor and surgeon in southern Illinois, and until
3 there's some clarity given, it's very difficult for
4 physicians to come in, to get on staff and say basically,
5 "You know, are you going to be here? Who is going to be
6 running the place?" So, until that has occurred --
7 Mr. Womick says that Ahmad and Osman are not going to work
8 together. That's his choice. He's on staff. He owns 30
9 percent. He's welcome at the surgery center. He does not
10 have to take his patients to his fully-owned surgery center
11 in Mt. Vernon. He can do surgery in Marion, Illinois, and
12 he will be welcomed. He'll have block time in accordance
13 with the block time procedures. He's welcome in that
14 surgery center. It's his choice. And then he comes up and
15 threatens the public and threatens the Board, that "if you
16 don't give me my way, I'll not do surgery in Marion
17 anymore."
18 MR. BURDEN: I've got a couple other
19 questions, if I might. I may be -- I apologize I was late.
20 I see the parent value in this surgery center in '07 was
21 8.8 million. Help me out about how sixty percent of -- or
22 is it 1.5 million -- you're able to purchase sixty percent
23 controlling interest of this facility ambulatory surgery
24 constantly treatment center.

1 MR. OSMAN: Well, in 2007, the surgery center
2 was -- Dr. Ahmad and his group were doing surgery there.
3 They were doing the majority of the surgery. I can give
4 you the numbers. In 2009, the net cash flow was a
5 $1,400,000. Dr. Ahmad pulled all of his surgeries out, and
6 in 2010 it lost $550,000. So, what occurred is exactly --
7 I mean, Rockefeller would be proud of the business plan.
8 You know, "We're going to pull it all out, run it in the
9 ground, buy it for peanuts on the dollar."
10 I think it's a good investment, and I believe
11 that the surgery center needs to remain in the control and
12 in the staff that's there now. And so the value is
13 reflective of the lower value of the surgery -- of the
14 income. Surgery centers are bought and sold on the basis
15 of cash flow and earnings before taxes and interest.
16 MR. BURDEN: So your answer is that the fact
17 that Ahmad -- who I don't know, I see his name has appeared
18 here -- pulled out or reduced his activity, caused the
19 significant change in the overall net return of the
20 investment into this surgery center; is that correct?
21 MR. OSMAN: That's correct. And in addition
22 to the fact that him and his group are 35 percent limited
23 partner owners and have a block -- had a block, basically,
24 on anyone else coming in.

1 MR. BURDEN: I find it interesting that you've
2 had so many oppositional letters. I apologize for not
3 listening to your defense of that, but I am concerned not
4 so much about that as I noticed that perhaps this is the
5 community you live in and work in. It says -- charity case
6 expense was listed at $3,615, and then the next line -- I'm
7 looking at the profile -- for the ambulatory surgical
8 center profile obtained regarding this facility -- zero.
9 Which is correct?
10 MR. OSMAN: As far as I know, it would be
11 zero. For what year are you talking about? I'm sorry.
12 MR. BURDEN: I have in front of me the Net
13 Revenue by Payor Source for Fiscal Year is labeled $3,615.
14 The next line says "Charity Care Expense as a Percentage of
15 Total Net Revenue", zero.
16 MR. OSMAN: I can't tell you about this
17 document, because we did not prepare it. I can tell you
18 that I have not been involved in the operation of the
19 surgery center, but my policy -- and I've already
20 instructed the staff -- is that we will not turn anyone
21 down.
22 MR. BURDEN: You hope that when you entice a
23 new ophthalmologist that you will have a return of
24 significant numbers, I presume, cataracts -- is that the

1 primary procedure that was done, or do you know that?
2 MR. OSMAN: No, the primary procedure that was
3 done was ophthalmological, cataract, retina, various
4 things. We have and have already increased a new doctor by
5 the name of Shawn Parker, and we're going to increase the
6 orthopedic -- we have two orthopedic surgeons that are
7 interested, four gynecologists, and the pain treatment is
8 increasing.
9 MR. BURDEN: Thank you.
10 MR. CONSTANTINO: Dr. Burden, an explanation
11 of that amount zero, that's a percentage. Our program
12 doesn't allow us to take it out to decimal amounts, so it's
13 less than .1 percent.
14 MR. BURDEN: I'm sure impressed there isn't
15 much Medicaid in your community or in the institution that
16 would be looking to help take the load off your busy
17 surgical center. Do I -- is this incorrect? Got five
18 beds? That's Heartland Regional Medical Center.
19 MR. OSMAN: No, that's incorrect. We only
20 have two operating rooms.
21 MR. BURDEN: I'm referring to where you
22 transfer any inadvertent problem that might occur because
23 of a misadventure or you need to have a patient sent to a
24 hospital. You have a hospital with five beds, or is

1 this -- does this mean five patients were referred?
2 MR. OSMAN: I believe -- again, this is not my
3 form, but I believe that's five patients were transferred.
4 MR. BURDEN: I know you don't know the answers
5 to some of these because you didn't own it, but it is
6 appropriate for us to know what's going on. That's why I'm
7 asking. The Heartland Medical Center--
8 MS. FRIEDMAN: It's not a five-bed hospital.
9 It's a general acute care hospital.
10 MR. BURDEN: So it's -- how far is it from the
11 proposed --
12 MR. OSMAN: Two and a half miles, and it's a
13 42-bed hospital.
14 MR. BURDEN: So the "five" refers to five
15 patients that were referred over a period of one year.
16 MS. FRIEDMAN: Having familiarity with the
17 form, that is what that means.
18 CHAIRMAN GALASSIE: Michael, do you agree with
19 that?
20 MR. CONSTANTINO: Yes, sir, that is correct.
21 MS. OLSON: I am just trying to get this all
22 in my head here, because this is my first meeting. If I
23 got this right, Mike is telling us that they have met --
24 the applicant has met all of the criteria of the

1 application.

2 MR. CONSTANTINO: They've met all of the

3 requirements of the exemption, that is correct.

4 MS. OLSON: And we know the TIF district is a

5 moot point. The building was already there. It's a non

6 issue. So what it boils down to -- and tell me if I'm

7 wrong -- if Dr. Ahmad was not in the issue, there would be

8 no issue.

9 MR. OSMAN: That is correct.

10 MS. OLSON: Thank you.

11 CHAIRMAN GALASSIE: Any other questions by

12 Board members?

13 MR. URSO: I just want to make sure I

14 understand. Can you confirm that you're going to maintain

15 ownership and control of the facility for a minimum of

16 three years? Is that correct?

17 MR. OSMAN: Absolutely.

18 MR. URSO: And that no services are going to

19 change that are currently being provided for at least

20 twelve months?

21 MR. OSMAN: That's correct.

22 MR. URSO: Thank you.

23 CHAIRMAN GALASSIE: And if this motion were

24 to be approved, would you consider accepting a condition to

1 the motion -- using, I believe, your words -- that no
2 individual patient would be turned away for an inability to
3 pay?
4 MR. OSMAN: Yes.
5 CHAIRMAN GALASSIE: And if so, there would be
6 an annual reporting for a two-year period back to the
7 Board --
8 MR. OSMAN: Yes.
9 CHAIRMAN GALASSIE: -- in that regard?
10 I'm going to recommend a motion to the Board
11 to approve change of ownership of Surgery Center of
12 Southern Illinois, a multi-specialty ambulatory surgical
13 center.
14 MR. PENN: I don't know if it was Mike or
15 George. What were the numbers again, opposing and
16 supporting? One was less than two hundred. One was --
17 MR. CONSTANTINO: Approximately 1,600 in
18 opposition letters and 115 in support.
19 MR. PENN: How big is Marion, Illinois?
20 MR. OSMAN: Marion is about 17,000 people.
21 The service area for Marion is somewhat larger. The
22 service area is probably 75 to 80,000.
23 If you look at the letters of opposition, they
24 come from Poplar Bluff, Missouri, they come from all over.

1 They come from Dr. Ahmad's patients. If you look at the
2 letters of opposition carefully, they believe the -- the
3 patients believe that if I am allowed to take over the
4 surgery center, that Marion Eye Centers will stop providing
5 services. Marion Eye Centers is a large, large service
6 provider. Dr. Ahmad has 32 different locations. So, these
7 letters, if you look at them very carefully, they're very
8 confused, because the public believes that if the big, bad
9 lawyer gets the surgery center, they have to drive to Mt.
10 Vernon for their surgery. Absolutely not true. They can
11 go to the other surgery center that's there. If Dr. Ahmad
12 wants to use it, they can come to where I am. As I say, I
13 welcome Dr. Ahmad. John Womick is wrong. I will have
14 nothing to do with the day-to-day operation as far as it
15 pertains to Dr. Ahmad. He's welcome to come and serve his
16 patients and to participate as he has since 1993.
17 CHAIRMAN GALASSIE: Are there other
18 questions?
19 MR. PENN: One more. I believe you said you
20 and your partners own other surgery centers?
21 MR. OSMAN: No, no. I have 14 partners in
22 other businesses, oil business, motel business, real estate
23 development, various other things.
24 CHAIRMAN GALASSIE: And so Board members

1 understand, you have a right to approve this; you can
2 disapprove this; you can defer it; and/or we can add a
3 condition, as I was suggesting a little bit earlier, for
4 not rejecting anyone for inability to pay. Questions?
5 MS. OLSON: I'm going to second your motion.
6 CHAIRMAN GALASSIE: The motion is a motion to
7 approve ownership of Surgery Center of Southern Illinois, a
8 multi-specialty ambulatory surgical center located in
9 Marion, with the condition that no patients will be turned
10 away for an inability to pay and that the owner will give
11 an annual report for two years back to the Board for the
12 status of clients who could not pay.
13 MR. URSO: I just want to make sure we have it
14 on the record in a verbal way that you agree to this
15 conditional permit the way it's stated.
16 MR. OSMAN: Yes, I do. I will agree that we
17 will not turn anyone down for an inability to pay. I will
18 report for two years, or whatever period of time the Board
19 would like.
20 CHAIRMAN GALASSIE: Now, pardon me. That is
21 a motion. I don't believe we have --
22 MR. BURDEN: So moved.
23 MS. OLSON: Actually, I didn't know you were
24 going to put that condition on there. I'm not going to

1 second it with that condition, because as the administrator
2 of a clinic, I don't know how you can expect somebody to
3 turn away nobody based on an inability to pay. I think we
4 can maybe ask them to make every effort or do a percent or
5 whatever, but to tell them that they can turn away
6 nobody --
7 CHAIRMAN GALASSIE: That's the condition of
8 the motion.
9 MS. OLSON: If he wants to agree with -- there
10 are going to be buses coming from all over the place, if
11 you do that.
12 MR. OSMAN: Here's the situation, ma'am. In
13 order for that to occur, the doctors have to also agree to
14 waive theirs, and I will match the doctors dollar for
15 dollar, and I've been very fortunate in life, and I don't
16 mind giving back. I was appalled, quite frankly, when I
17 saw what was there. Whenever we owned it in 1986, we
18 didn't turn anyone down, and I will not turn anyone down.
19 So I understand -- and, believe me, I don't say it lightly.
20 But, you know, if I begin to get dumped on because
21 everybody is bringing Public Aid cases there, then I'll
22 have to --
23 CHAIRMAN GALASSIE: We'll see those numbers.
24 MR. OSMAN: We'll see those numbers.

1 MS. OLSON: Then I will second.

2 CHAIRMAN GALASSIE: Point of order, we have a

3 motion. We have a second?

4 MS. OLSON: Yes.

5 CHAIRMAN GALASSIE: We have a motion and a

6 second.

7 MR. CONSTANTINO: Mr. Chairman, is this going

8 to be an annual report?

9 CHAIRMAN GALASSIE: Two years.

10 MR. CONSTANTINO: Two years, annual report?

11 CHAIRMAN GALASSIE: Right.

12 We have a motion and a second, with the

13 condition. Seeing no other questions, roll call, please.

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

15 seconded by Ms. Olson.

16 Dr. Burden?

17 MR. BURDEN: No.

18 MR. ROATE: Mr. Eaker?

19 MR. EAKER: Yes.

20 MR. ROATE: Justice Greiman?

21 MR. GREIMAN: Yes.

22 MR. ROATE: Mr. Hayes?

23 MR. HAYES: Yes.

24 MR. ROATE: Mr. Hilgenbrink?

1 MR. HILGENBRINK: Yes.

2 MR. ROATE: Ms. Olson?

3 MS. OLSON: Yes.

4 MR. ROATE: Mr. Penn?

5 MR. PENN: No.

6 MR. ROATE: Mr. Sewell?

7 MR. SEWELL: Yes.

8 MR. ROATE: Chairman Galassie?

9 CHAIRMAN GALASSIE: Yes.

10 MR. ROATE: That's 7 votes in the affirmative,

11 two notes in the negative.

12 CHAIRMAN GALASSIE: Motion passes.

13 It's five to eleven. We're going to take

14 about a ten-minute stretch right here.

15 (Recess)

16

17 CHAIRMAN GALASSIE: We'll pull the meeting

18 back to order, please.

19 Moving forward, we are at Item 7-D, Alteration

20 Requests. We have none.

21 Declaratory Ruling Requests, Item E, 7-E, we

22 have none.

23 Item 7-F, Healthcare Worker Self-Referral Act,

24 we have none.

1 And the Status Report on Conditional Permits,
2 we have none.
3 We go to Item 7-H, we are going to have a
4 discussion of our inventory regarding hospital long-term
5 care, and Mr. Carvalho has agreed to conduct that for us,
6 to try to give Board members some perspectives, before we
7 go forward on the remaining portions of the agenda. We
8 will get there, I promise.
9 MR. CARVALHO: Thank you, Mr. Chair.
10 I've handed something out to the Board
11 members, and I'm not going to read it out loud but rather
12 we'll kind of work through it conversationally. The
13 purpose of this document -- and it's something you can
14 refer to either while I'm talking or afterwards. The
15 purpose of this is to refresh the recollections of those
16 who already knew it and to more deeply inform the new Board
17 members of what exactly our inventory is. It comes up in a
18 critical way in most applications before the Board, and so
19 wanted to take this moment, before you turn your attention
20 to these applications, to remind you or inform you of what
21 is the inventory and what is it not.
22 The Department uses a methodology spelled out
23 in the rules of the Board and follows the practices
24 consistently over the years to give you one measure of need

1 for certain types of services in each of the planning areas
2 for those types of services. It is one measure of need,
3 and you'll notice in many of your State Agency Reports that
4 you have multiple measures of need. So, in the case of,
5 for example, hospital beds, you may have the number from
6 the inventory of there are 42 excess beds or there are
7 72 -- a deficiency of 72 beds, and then you'll notice that
8 other elements of the State Agency Report will also look at
9 other measures, for example the utilization rate of the
10 facilities within the vicinity of the proposed application.
11 And each of those measures has its strengths and
12 weaknesses, and it's part of the reason why this is not a
13 process for automatons, where the State Agency Report says
14 yes or no and the State Board follows that exactly, but you
15 have to use your judgment and your discretion in
16 interpreting these several measures.
17 So, let me focus on the one in particular
18 that's described in this sheet about the inventory. The
19 inventory is recalculated every several years, and the goal
20 of the inventory with any particular planning area is
21 pretty basically stated. Tally up the number of beds that
22 are needed, tally up the number of beds that are present,
23 and look at the difference. In many of the planning areas
24 currently you'll find that the number will be a positive --

1 a negative number, which means there's an excess of beds
2 using that measure, and then in some of the planning areas
3 for some types of services it will be a positive number.
4 But several of you asked the Executive Director -- or the
5 Administrator and others of us, "I see applications where
6 the inventory calculation shows a need but the utilization
7 shows large amounts of under utilization. How can those
8 both coexist at the same time?" So, in discussions, we
9 thought perhaps it was a good time to remind everybody
10 exactly how the inventory is put together.
11 The process is to take a base year. In the
12 case of the inventory that you're currently using, this was
13 done in 2008, so the base year was 2005. That was the year
14 where you had the most recent data available on all of the
15 different dimensions. So, in 2008, we looked at the 2005
16 utilization -- in other words, how many hospital beds were
17 actually being used for a given population -- and then
18 project -- took projections 10 years into the future of
19 what the population in 2015 was projected to be. The
20 source for utilization was the annual surveys that are done
21 on your behalf each year, asking hospitals in this case how
22 are their facilities being used. The projections on
23 population are the State projections done by the Department
24 of Commerce and Economic Opportunity, DCEO. So, DCEO in

1 2005 and 2006 contracted with someone to do projections
2 into the future every five years. So, DCEO came with
3 projections for 2010, 2015, 2020, 2025, 2030. The
4 Department then took those projections for 2015 and our
5 state demographer broke it down into your planning areas.
6 This is a zero sum process. If you make an estimate for
7 Planning Area 1, Planning Area 2, et cetera, they have to
8 all total up to the total that the DCEO projected for 2015.
9 So, our demographer took the total, broke it down into your
10 planning areas, and used those projections to take 2015 in
11 2005.
12 So, if you're following me so far, the way you
13 do the math is in 2008, we looked at how things were
14 utilized in 2005. We projected to 2015 how things would be
15 used, and that's the number that you come up with for the
16 need in the planning area.
17 There's a few additional twists I'll just
18 touch on but not dwell on. In some planning areas, people
19 have been getting their care in other planning areas, and
20 we keep track of that using our hospital discharge data.
21 Those are data that another office in the agency, my
22 office, collects. So, we adjust the inventory to take into
23 account a fraction of that; namely if people in one
24 planning area are getting their care in another planning

1 area, certainly some of that is driven by choice, but a
2 presumption is that some of it is driven by the lack of
3 availability of facilities in their own area. So, we
4 assign need to the area of origin and we subtract need to
5 the area where they're currently getting their care.
6 After you do all of this, you tally up the
7 number for need. So when you hear or you see in one of
8 Mike's or George's State Agency Reports that for this
9 planning area, there is a need for 43 beds or there is an
10 excess of 43 beds, it's because of the total estimated need
11 in 2015, using this process I just described, minus the
12 number that are there now, is that gap or is that excess.
13 It doesn't mean that there is a need yesterday or today,
14 but it's a need -- or there might be, but it's a need
15 projected for 2015.
16 Now, the thing that you need to know that's a
17 little different today than a year ago or two years ago
18 when you used the same inventory is that since that time,
19 the 2010 census has come out, and so there are two numbers
20 available to you. One is -- I mean, available to us or to
21 one: The projected 2010 population for the state of
22 Illinois and the counties of Illinois, and the actual 2010
23 population, and it might not surprise you to know that
24 although these projections were done in 2005 and 2006, in a

1 number of cases they are dramatically off in particular
2 because of the change in the economy in the last half of
3 the last decade. Especially in an area that's experiencing
4 a lot of growth it doesn't take much for that -- for a
5 deflection in the curve of that growth to get you to a
6 different point.
7 Because I printed these out this morning on my
8 home computer, I did not print out the couple pages
9 attachment that's referred to in this one-pager. I have an
10 attachment that I will get to you for your information that
11 shows for every county the difference between the
12 population that was projected for that county in 2005 and
13 2006 for 2010 and the population that was found in the 2010
14 census to reside in that county. I highlighted in the text
15 the larger counties that have the largest deviation. So
16 you can see that Kendall County and Grundy County and Boone
17 County far exceeded 40 percent, 16 percent and 16 percent,
18 the population that was projected for those counties in
19 2005. Conversely, McHenry County and Lake County far --
20 came in far under what was projected. In particular,
21 McHenry County came in 9 percent under and Lake County 8
22 percent under the projection in 2006.
23 This highlights for you one of the reasons why
24 you exist, because when you get an application, you have

1 rules that say X amount bed need and Y amount utilization,
2 but you need to be able to consider and interpret those in
3 the context of the applications in front of you. And so
4 our prior experience -- Courtney and Frank and I were here
5 several years ago when the discussion of new hospitals in
6 particular came up, and there was intense conversation by
7 the applicants and by opponents of where these numbers came
8 from, how they were derived, where they were going, what
9 they were based on, et cetera, and Courtney and I discussed
10 this and thought it might be useful for you to hear it from
11 us first, before the applicants start debating whether the
12 projections are good, bad, indifferent, what do they mean,
13 where are they going, et cetera.
14 If there are any questions, I'll be happy to
15 take them. Otherwise --
16 MR. GREIMAN: When you're off 42 percent in
17 Grundy County, do you change the numbers then, or do you
18 just say, "Well, we're wrong, but let's keep the numbers
19 what they are"?
20 MR. CARVALHO: Judge, every component of the
21 calculation that creates an inventory changes from month to
22 month and year to year, and so rather than have a process
23 where the inventory is changing every month, you have a
24 process in place where the inventory is updated

1 periodically. So we ask that you keep in mind that as the
2 inventory gets older or as the projections deviate from
3 what was expected, that you need to interpret your
4 inventory in that light. So, for example, you need to
5 realize --
6 MR. GREIMAN: Is that a yes or a no?
7 MR. CARVALHO: I'm not on trial, but it's a
8 no. We do not update it from moment to moment. We have a
9 process for it to be updated. It will be updated over the
10 course of the coming year. But even that update will
11 itself be out of date the moment it's released, because of
12 the deviation between trends and population and actual
13 trends. So you will always have to be mindful of the
14 weaknesses of the inventory and what exactly it tells you,
15 and we will both respond to questions and periodically keep
16 you apprised of those trends.
17 MR. SEWELL: David, how difficult would it be
18 for the Director of Public Health to ask the Director of
19 the DCEO to do Health Service Area and population
20 projection, because the variability in population growth
21 around the state is extraordinary. So you're taking a
22 state-wide population projection and forcing it into the
23 health services.
24 MR. CARVALHO: It would depend on whether he

1 was carrying his checkbook at the time he asked the
2 question. You should know that this very conversation is
3 going on now. How are these projections going to be
4 updated? I'll try to be brief but give you a flavor of it.
5 One of the things everybody who filled out the
6 census -- which I hope is everybody in the room -- knows
7 that nobody got the long-form census this year. One of the
8 things the long-form census used to do was include
9 information about where did you move from, if you moved in
10 the last five years, and that's one of the things that
11 people use to do projections of a migration population.
12 Since that wasn't done and instead we're going to be
13 relying on the American Community Survey, which is a
14 post-census thing, the ability to do meaningful projections
15 really doesn't exist as we sit here right now. So, we're
16 going to have to wait for those American Community Surveys.
17 In the meantime, we can do the contracting -- which you
18 know how speedy State contracting is -- to secure the
19 services for somebody. The issue right now, not
20 surprisingly, is how is that going to be paid for, because
21 there's nothing in the last budget to pay for it.
22 CHAIRMAN GALASSIE: But the plan, for all
23 intents and purposes, is the plan and that's the level
24 playing field that everyone is operating from.

1 MR. CARVALHO: Everyone is operating from it,
2 and you will hear -- if past is any prediction, you will
3 hear people argue either side of this, depending on how it
4 affects their application, and we wanted to give you an
5 objective statement of what's wrong about the inventory and
6 what's weak about it and acknowledge that.
7 CHAIRMAN GALASSIE: Thank you very much.
8 We are going to move forward now with Item I,
9 No. 1, 10-089, Mercy Crystal Lake Hospital. We have
10 approximately how many public comments?
11 MS. AVERY: Fourteen.
12 CHAIRMAN GALASSIE: We have fourteen people
13 who have asked to speak. Again, if you could please try
14 and keep your comments focused into a couple of minutes, we
15 would greatly appreciate that. When you do come up -- and
16 we'll keep you introduced a couple ahead -- if you'll
17 introduce yourselves and be sworn in, and following that,
18 we will have the applicant here.
19 If Board members can, we would prefer to hold
20 questions for the applicants rather than those individuals
21 representing the public.
22 That having been said, if you're a member of
23 the public and you're coming up to speak for your two
24 minutes and you desire to speak if you're for or against,

1 you have every right to do so, nor do you have to do that.
2 If you would prefer to advise us of your stand, feel free
3 to do so.
4 We're going to try to cue up. We'll read
5 three or four names at a time so we can cue up to move
6 things along.
7 (Ms. Avery identifies individuals by name.)
8 MR. URSO: If everybody can, please sign the
9 yellow pad that's by the microphone.
10 CHAIRMAN GALASSIE: Good morning.
11 MR. COLBY: Good morning. I'm Dan Colby.
12 MR. KURTZ: I'm David Kurtz.
13 MS. BORTNER: I'm Barb Bortner.
14 MR. COLBY: Good morning, Mr. Chairman and the
15 Board. First of all, I'd like to thank you for the
16 opportunity to speak this morning and, secondly, I'd like
17 to mention that I did speak at the public hearing but on a
18 different topic.
19 As far as myself, I've lived in Harvard,
20 McHenry County, Illinois for the last 15 years. I serve on
21 the Harvard and McHenry County Economic Development
22 Commissions. During this time, I have had a close,
23 personal view of McHenry County's significant growth in
24 population, retail industry, and the need for healthcare

1 services. In 2003, the Mercy Health System answered direct
2 patient needs of McHenry County when it purchased Harvard
3 Hospital and invested over $20 million over the next
4 several years to provide excellent healthcare services for
5 the patients of northwest McHenry County. This area's
6 healthcare needs are now well served.
7 The southeast area of McHenry County also
8 needed a hospital. But today, eight years later, the
9 population of southeast McHenry County is a staggering
10 160,000 people, and still there is no hospital. Centegra
11 continues to ignore this area because that 160,000 people
12 include the greatest concentration of Medicaid recipients
13 in McHenry County, the greatest number of elderly in
14 McHenry County, even more than Del Webb in Huntley -- and
15 this is per the 2010 census -- the greatest minority
16 population in McHenry County -- again, per the census --
17 the greatest number of patients needing public
18 transportation to healthcare services in McHenry County --
19 and that's per Metra and Pace -- the greatest number of
20 patients needing ambulance transport to emergency
21 services -- and that's per the Crystal Lake Fire and Rescue
22 Chief.
23 Today Mercy wants to invest $200 million to
24 serve the still needy community. On the other hand,

1 Centegra has chosen to ignore this need for the last eight
2 years and instead wants to bypass this critical area to
3 follow the growth and new money of Huntley. Of Huntley's
4 26,000 people, over 10,000 are comfortably retired
5 individuals in new condos, who do not have healthcare
6 access problems. Centegra had eight years of opportunity
7 to serve the greatest need in McHenry County --
8 CHAIRMAN GALASSIE: Stay on course.
9 MR. COLBY: I'm sorry.
10 I just wanted to urge the Board to approve
11 what is needed now, and what is needed now is the Crystal
12 Lake Hospital, where the population is and where we don't
13 have to worry about population growth and what the need
14 might be in the next three to five to eight years.
15 Thank you.
16 MR. KURTZ: Good morning. I would like to
17 thank the members of the Health Facilities Planning and
18 Services Review Board for the opportunity to address the
19 critical issues of timing and cost for this very important
20 project.
21 CHAIRMAN GALASSIE: And your name, sir?
22 MR. KURTZ: David Kurtz.
23 CHAIRMAN GALASSIE: Thank you.
24 Our country has been slow to recover from the

1 deepest recession that any of us have seen in our lifetime.
2 As a result, the construction industry has experienced
3 intense pressure to hold down building costs in order to
4 generate a sustainable level of business through these
5 trying economic times. Subsequently, with new construction
6 pricing currently at bargain basement levels, now is the
7 time when any project would benefit fiscally from a bid
8 perspective within the current economic environment.
9 Mercy is uniquely positioned to start this
10 project within the current calendar year. This will not
11 only maximize the purchasing power of each and every
12 capital dollar spent, but provide a much-needed boost to
13 the local construction industry as well. With a projected
14 total project cost of $200 million, the 128-bed Mercy
15 Health System proposal is already 33 (inaudible) Centegra
16 project of $233 million. Common sense would seem to
17 dictate that as the economy improves and back-up building
18 projects are brought forward for implementation,
19 construction costs will follow demand, and rise
20 accordingly.
21 The Centegra project is not anticipated to
22 begin earlier than the end of 2014. Following historical
23 trends, we can expect prices to increase significantly over
24 that period of time. The current gap of 33 million between

1 the two projects could widen dramatically as the inflation
2 pressure associated with this delay becomes a factor with
3 the Centegra project. The higher project costs associated
4 with the existing Centegra proposal, coupled with the
5 inflation area spiral brought on by the delay, will
6 translate directly to higher healthcare costs for McHenry
7 County. In turn, this added burden will have influence on
8 the ability of McHenry County residents to access
9 appropriate healthcare services.
10 It is readily apparent that Mercy Health
11 System's proposal is the right project at the right place
12 at the right time. Thank you for your consideration.
13 CHAIRMAN GALASSIE: Thank you.
14 (Ms. Avery identifies individuals by name.)
15 CHAIRMAN GALASSIE: Thank you.
16 MS. BORTNER: Thank you for the opportunity to
17 address the Board today. My name is Barb Bortner, and I am
18 Vice-President for Mercy Health System.
19 Mercy's mission is to provide exceptional
20 healthcare services, resulting in healing in the broadest
21 sense. "Healing in the broadest sense", for Mercy these
22 five small words make all the difference. Imagine for a
23 moment you live in a community like Harvard, Illinois, a
24 community we are privileged to serve. In 1996, you may

1 have attended an open house at our newest hospital in
2 Harvard and taken part in one of the free health screenings
3 or wellness checks we offered to the Harvard residents.
4 Today you might visit one of our 87 primary and specialty
5 care physicians at our 17 Illinois clinics. If you need
6 hospital care, Harvard Hospital, with more than $20 million
7 in renovations and service expansions, is ready to care for
8 you. You might marvel that this hospital was once on the
9 verge of extinction. Not only did Mercy renovate the
10 facility but also enhanced the services and technology
11 offered to the residents of the Harvard community, and last
12 year alone, we touched the lives of over 8,000 residents in
13 the town of Harvard.
14 System wide, Mercy provides $38 million in
15 uncompensated care and free services to our communities.
16 In Illinois, we provide more charity care as a percent of
17 revenue than any other health system in McHenry County. As
18 part of the Mercy family of 17 clinics in Illinois
19 communities, over 87 Illinois, employed physicians provide
20 over 60 specialty services. These dedicated physicians
21 participate in over 5,000 free screenings, health classes,
22 physician presentations, and wellness talks each year. We
23 also enjoy working side-by-side with many community
24 organizations by sponsoring and participating in hundreds

1 of events, walks and fairs each year.

2 We don't measure our ability to serve by the

3 wealth of a community or its residents. Mercy is committed

4 to doing whatever it takes to keep McHenry County, every

5 part of McHenry County, healthy and strong.

6 Thank you for your consideration.

7 CHAIRMAN GALASSIE: Thank you, Barb.

8 If you folks can please be sworn in, and then

9 as you individually speak, you can introduce yourselves.

10 (Oath given)

11 MS. LAMBERT: Good morning. I'm Karen

12 Lambert, President of Advocate Good Shepherd Hospital, and

13 I want to thank you for giving me the opportunity to speak

14 today. We have a number of speakers who are coming to

15 share their concerns about this project, but many are in

16 the room because of their concern for the impact on these

17 hospitals, and I would ask that they stand today just to be

18 acknowledged.

19 (Pause)

20 MS. LAMBERT: I'm here today because this

21 hospital will have a significant negative impact on many of

22 the area hospitals and is truly inconsistent with our

23 collective responsibilities to be stewards of the

24 healthcare resources. One of the primary purposes of the

1 Planning Act is to prevent unnecessary duplication of
2 services, and I believe this project does that. Existing
3 hospitals need sufficient volume to cover their overhead.
4 Within any given area, there are only so many babies to
5 deliver or so many surgical procedures to perform. A new
6 hospital will not create new demand. Without sufficient
7 patients, hospitals can't continue to reinvest in the
8 future or take care of patients who don't have the ability
9 to pay.
10 If I can explain a little bit more, there's a
11 few key items. We need better care, not more care. We're
12 concerned with our safety net services. As a faith-based,
13 not-for-profit, mission-oriented organization, Advocate
14 Healthcare provides more indigent healthcare than any other
15 provider in the state of Illinois. The impact of this
16 hospital seriously impacts the ability for area hospitals
17 to provide safety net services.
18 In a few minutes, you're going to hear from my
19 colleague, Michelle Gaskill, who is going to explain how
20 the resources at Good Shepherd are vital to carrying on our
21 mission at Advocate and serving some of the under served
22 areas. We believe there is no need under the review rules,
23 and we're grateful that the State Agency Report has
24 confirmed that this project is an unnecessary duplication

1 of services.

2 And then lastly, we don't believe there's a

3 practical need. There's no patient who is going untreated

4 because an area hospital is full. Every resident has a

5 hospital within 30 minutes, and 90 percent of the residents

6 have a hospital within 15 minutes. We believe this project

7 will negatively impact area hospitals, and it is not

8 responsible use to healthcare resources, so we urge the

9 Board to deny this project.

10 Thank you.

11 CHAIRMAN GALASSIE: Thank you.

12 MR. FLOYD: Good morning. My name is Rick

13 Floyd. I'm the President and CEO of Sherman Health, which

14 is based in Elgin, Illinois. Sherman has been serving the

15 Northern Fox Valley service area for 23 years. I am here

16 today to oppose this application, because there is no need

17 for additional beds in our service area. All of the

18 adjacent hospitals have unused capacity. The State Report

19 identified utilization rates for medical/surgical beds of

20 74.5 percent for the five surrounding hospitals and 45.5

21 percent in OB for those same hospitals.

22 Also, you are aware that the impact of

23 healthcare reform upon all hospitals will be to reduce

24 hospital utilization rates as we strive to prevent

1 unnecessary readmissions and to find more cost-effective
2 ways to treat patients in the outpatient arena. Therefore,
3 if you build a new hospital, it hurts all the existing
4 hospitals. In the case of my hospital, we estimate that
5 this application, this new hospital, would take about 2,000
6 admissions away from us. That's about 15 percent of our
7 volume, and that would put a big dent in anyone's revenue,
8 and this happens at a time, also as a result of healthcare
9 reform, when reimbursement rates, when payment rates to
10 hospitals and doctors are expected to decline
11 significantly.
12 So, why does this matter to the Planning
13 Board? It matters, as Ms. Lambert pointed out, because it
14 calls into question the strength of our safety net. All of
15 us provide services to those who cannot pay, to those who
16 are part of Public Aid, and this is going to place
17 additional strain for all of the existing hospitals. Also,
18 as Mr. Carvalho pointed out in his very clear and helpful
19 explanation, the population projections that serve as the
20 basis for these applications and also for the bed-need
21 estimates were based on over estimates, significant over
22 estimates of population. Therefore, there is no existing
23 bed need, and there will be no need for quite a while.
24 So, I urge the Board to reject this

1 application. It's a waste of public resources at a time
2 when state and federal budgets are experiencing historic
3 Imbalances.
4 Thank you.
5 CHAIRMAN GALASSIE: Thank you.
6 MR. NEMETH: Hello, my name is Joe Nemeth, and
7 I am the Chief Operating Officer of Mercy Care Insurance
8 Company. I'm here today to speak to you about why I
9 believe you should approve the CON for Mercy Health System
10 to build the Mercy Crystal Lake Hospital.
11 Mercy Care Health Plans has been a licensed
12 Illinois insurer for the past 10 years, and I can tell you
13 firsthand that without significant new competition to the
14 Centegra Health System, there is little belief, little
15 reason to believe that there will ever be multiple insurers
16 serving the McHenry County market. With inpatient and
17 outpatient costs accounting for about 50 percent of the
18 total health insurance bill, Centegra Health System by its
19 monopoly in that area dictates what insurance companies
20 operate in McHenry County. Because Mercy Care is a
21 wholly-owned subsidiary of the Mercy Health System,
22 Centegra has basically been -- we've been unable to
23 compete, because Mercy Health System operates a competitive
24 provider network to Centegra. So, basically the Mercy Care

1 Insurance Company has not been able to get contracts with
2 Centegra that would be equivalent to what they give to Blue
3 Cross/Blue Shield of Illinois, for example. There is no
4 requirement by any health provider in this area to contract
5 with any insurer under any rates. So, even though the
6 health CON process attempts to control costs by avoiding
7 duplication of services, because of the lack of competition
8 in this marketplace, I believe it is actually increasing
9 costs. This finding is consistent with the 2007 U.S.
10 Department of Justice and the U.S. Federal Trade
11 Commission's study that talked about CON and it's impact on
12 competition and on cost.
13 Also, Mercy is a vertically-integrated
14 delivery system which coordinates care from a physician
15 office through the hospital services, and this model has
16 shown to be a cost-effective model. For these reasons I
17 encourage you to approve the Mercy Health System CON.
18 Thank you.
19 CHAIRMAN GALASSIE: Thank you.
20 (Ms. Avery identifies individuals by name.)
21 (Oath given)
22 MS. RIPSCH: Hello. My name is Sue Ripsch,
23 and I'm Vice-President of Mercy Health System. Thank you
24 for this time to share my thoughts about the Mercy Health

1 System commitment to the residents of McHenry County.
2 In 2003, Mercy Health Systems assumed the
3 operations and financial responsibility for Harvard
4 Memorial Hospital in Harvard, Illinois. At that time,
5 Harvard Memorial Hospital had reached financial insolvency.
6 They sought out two area providers, Mercy Health System and
7 Centegra Health System, looking to find a partner. When
8 meeting with Centegra, Harvard Hospital was told that they
9 could join but that Centegra planned on essentially
10 shutting them down and moving their services out of town.
11 Please be aware that Harvard has a lower social economic
12 level than many other areas in McHenry County and that
13 healthcare is sorely needed by this community.
14 When meeting with Mercy, Mercy made the
15 commitment to not only keep the facility open but to
16 improve the physical plant and expand services to the
17 residents of Harvard and the surrounding area. In honoring
18 that commitment to the Harvard area residents, Mercy has
19 injected $20 million into the facility with improvements in
20 the operating rooms, the emergency department, lab,
21 radiology, long-term care, and respiratory services. We
22 have computerized the inpatient medical records with an
23 electronic medical record system. This has been at a cost
24 but has greatly benefited the community.

1 Incidentally, none of these projects met the
2 capital project threshold. We have added many physicians
3 and physician services to the hospital. We would do the
4 same at the Crystal Lake Hospital, if approved. In
5 addition, Mercy's policy is to give healthcare to those
6 patients Mercy serves, including the proposed hospital at
7 Crystal Lake, regardless of their ability to pay. Again,
8 no other healthcare provider in the county was willing to
9 step up and invest in the healthcare services for a very
10 needy area of McHenry County as we have done in Harvard.
11 Mercy Health System is committed to all
12 residents of McHenry County. We do not pick and choose who
13 we care for. Mercy has the financial means and the
14 commitment to meet the needs of the residents of this area.
15 I recommend that you approve the Mercy CON request for a
16 needed hospital in Crystal Lake.
17 Thank you.
18 CHAIRMAN GALASSIE: Thank you.
19 MS. GASKILL: Good morning. My name is
20 Michelle Gaskill. I'm the Vice-President of Nursing and
21 Clinical Operations at Advocate Trinity Hospital, and I'd
22 like to start out by thanking you for giving me the
23 opportunity to speak to you today. You may be wondering
24 why I'm speaking from a hospital's standpoint that is

1 actually 60 miles away from the healthcare landscape that
2 we're talking about. But the answer to that is Advocate
3 loses millions of dollars every year serving Chicago's
4 south side. When the financial strings of Advocate Good
5 Shepherd are threatened, our inner city mission is to serve
6 those in need. I'm very proud to say that Trinity right
7 now ranks nationally in the top 10 percent of hospitals as
8 it relates to heart attacks, to stroke, pneumonia, and also
9 surgical care. We just got designated as a Stroke Center
10 of Excellence, which was critical to our community, because
11 our zip code where the hospital resides is actually the
12 highest incident of stroke in all of Illinois. This over
13 the years has only been possible because of investments
14 that Advocate has made in Trinity, despite the fact that
15 reimbursement tends to be low and charity care is high.
16 From 2006 to 2010, Advocate lost $31 million
17 in the Trinity service area and provided $47 million in
18 charity care, despite those losses, and spent $5 million to
19 build services, such as a wound care center, that will meet
20 the needs of our population. Trinity can only continue to
21 thrive and build these services for our community because
22 of the income from operations and communities like
23 Barrington. A recent study estimated that if the Crystal
24 Lake hospital is built, hospitals in the immediate area

1 would lose $144 million in revenue and $51 million in
2 contribution margin. These losses will undoubtedly
3 adversely impact the communities those hospitals serve.
4 Yet that's only half the picture. A new
5 hospital in McHenry County will have adverse consequences
6 for families on Chicago's south side for all of the reasons
7 that I mentioned. So, I'd like to ask this Board to vote
8 no on this proposal.
9 Thank you very much for your time and
10 attention.
11 CHAIRMAN GALASSIE: Thank you, Michelle.
12 MR. STILSON: Thank you for allowing me to
13 have the opportunity to speak today. My name is
14 Dr. Matthew Stilson. I'm the Medical Director for the
15 Emergency Department and the Urgent Care Center at Sherman
16 Hospital. I'd like to address the issue of providing
17 state-of-the-art emergency department services in our area.
18 On the surface, it may appear that building
19 emergency rooms, building more emergency rooms in more
20 locations, would improve emergency care. But actually the
21 most important element in a true emergency is how long it
22 takes the paramedics or the EMT's to reach and stabilize
23 that patient. The time it takes the ambulance to drive the
24 patient to the hospital is less crucial. It's also

1 important to put trauma care in perspective. Approximately
2 1 in 100 patients seen in the emergency room represents a
3 true trauma case. The vast majority of cases are far less
4 urgent.
5 Once a patient with a life-threatening
6 condition arrives at a hospital, it's important that that
7 facility have the right team ready to treat the patient and
8 do surgery immediately, if necessary. Sherman's
9 state-of-the-art emergency department is already providing
10 that type of quality care very efficiently for patients in
11 southern McHenry County. We're also well prepared for all
12 those patients when they arrive at the emergency
13 department, because we've been in close communication with
14 paramedics who are treating the patient. Often our
15 treatment begins before a patient even arrives at our door.
16 Sherman is meeting the emergency room needs of
17 the area right now and is committed to continuing in that
18 role. I urge the Board to reject the new hospital
19 construction in our area. I believe it would be a costly
20 duplication of services.
21 Thank you.
22 CHAIRMAN GALASSIE: Thank you.
23 MR. GORDON: Good morning. My name is Trent
24 Gordon, and I'm the Director of Business Development and

1 Strategic Planning at Advocate Good Shepherd Hospital. I'm
2 opposing the proposed Mercy Hospital. Approving the Mercy
3 Hospital would cause an unnecessary duplication of services
4 in the area.
5 So, you may wonder if there are so many
6 hospital choices, why then is there a calculated need for
7 83 more medical/surgical beds? The bed need is primarily
8 based on recapturing the patients leaving the county for
9 care. The calculation of the 83 med/surg beds is based on
10 patient utilization off of a base year of 2005, multiplied
11 by a factor to account for the forecast growth and the
12 aging of the population through 2015. As Mr. Carvalho
13 pointed out, the population projections for this particular
14 planning area were 9 percent higher than what the actual
15 census showed. However, the forecast utilization for 2015,
16 based on the over-stated population and aging, shows the
17 bed need for only some of the 83 beds.
18 So you're probably wondering why then is the
19 application citing the bed need for 83? The reason is that
20 some of the 83 bed need is based on recapturing a lot of
21 the patients who are currently leaving the county to go to
22 hospitals located outside of the county. I think that
23 "recapturing" is an interesting word here. Patients are
24 going to other hospitals out of choice, because as you have

1 heard, there are empty beds in McHenry County. I should
2 mention that many of those beds included in the calculated
3 83 would, according to the formula, be recapturing patients
4 traveling less than one mile beyond the county border to
5 Good Shepherd. A lot of these patients are also going to
6 academic medical centers downtown and specialty hospitals,
7 such as the University of Illinois Medical Center and
8 Children's Memorial, to receive care not currently offered
9 or planned to be offered by the applicant. In fact, if
10 Good Shepherd were located one mile west of its current
11 location and was in McHenry County, then at least 20 fewer
12 med/surg beds would be needed in McHenry County, or only 63
13 beds and, in fact, if you recalculated the population,
14 basing it on a 9 percent lower base, which is what the
15 census demonstrated, off of 300 bed need, there would be 29
16 fewer bed than that, meaning that there would be a
17 calculated need of only 34 med/surg beds, which is far less
18 than the 100 med/surg beds needed for a new hospital.
19 I urge the Board to take this into account as
20 you make a decision. Thank you.
21 CHAIRMAN GALASSIE: Thank you, Trent.
22 (Ms. Avery identifies individuals by name.)
23 (Pause)
24 CHAIRMAN GALASSIE: Good morning, and if you

1 folks can all be sworn in together and sign in on that
2 sheet as well, and then introduce yourselves individually
3 as you speak to the Board, please.
4 (Oath given)
5 MS. DEERING: Good morning. I'm Linda
6 Deering, Executive Vice-President and Chief Operating
7 Officer for Sherman Health, and thank you for letting me
8 verbalize my opinion about opposition for this hospital,
9 and it's based on the Comprehensive Health Planning issue.
10 Let me explain.
11 Sherman Health believes that until the State
12 establishes a Center for Comprehensive Health Planning, the
13 Illinois Health Facilities and Services Review Board should
14 not consider applications for a new hospital at this time.
15 As you know, the Center for Health Planning was a crucial
16 part of the Illinois General Assembly's 2009 rewrite of the
17 Illinois Health Facilities Planning Act. It makes sense
18 then to honor the Legislation's direction by deferring any
19 new hospital applications until that center is established.
20 The Center for Health Planning will provide very important
21 planning assistance to the Board. The Center will analyze
22 CON applications, review reports and statistics related to
23 those applications for new hospitals. Ultimately this and
24 in-depth planning will help the Board make decisions that

1 ensure access to healthcare for under served populations
2 and promote efficiency. This will also ensure that
3 existing hospitals remain in strong financial health so
4 that they can continue to serve the patients who are most
5 in need.
6 Healthcare efficiency is critically important
7 for the fiscal well-being of our state and our nation.
8 Taxpayers pay for more than half of the healthcare costs in
9 this country through Medicare and Medicaid. The Centegra
10 and Mercy hospital proposals would create a duplicative,
11 inefficient healthcare environment, and everyone will pay
12 for it as insurance costs rise to pay for more buildings
13 that are staffed 24/7, even if they're under utilized. The
14 plans from Centegra and Mercy go to the core of what the
15 Comprehensive Planning function is intended to address,
16 whether population growth has truly occurred, utilization
17 rates of existing healthcare providers, the regional
18 implications of pending projects.
19 We hope that Mercy and Centegra projects and
20 all other new hospital applications will receive the kind
21 of analysis they need before the Board makes any decisions
22 of this magnitude. In closing, we encourage the Board
23 members to take advantage of this opportunity provided by
24 the State law. The Center for Comprehensive Health

1 Planning will give Board members the kind of in-depth
2 analysis they need before voting on these proposals. When
3 this much is at stake for our most vulnerable residents and
4 all taxpayers, it's clear that this center is needed now
5 more than ever.
6 Thank you for letting me be heard.
7 CHAIRMAN GALASSIE: Thank you.
8 MR. RYDER: Good morning. My name is Doug
9 Ryder I'm the Vice-President of Operations and Service
10 Lines for Advocate Good Shepherd Hospital. I'm here to
11 voice my opposition. I'm asking the Board basically to do
12 what's practical. Denying these applications today won't
13 negatively impact the health of McHenry County residents.
14 If you vote no, there won't be a resident who needs surgery
15 that doesn't get surgery. There won't be a woman who
16 doesn't deliver at a nearby hospital. All of the residents
17 of the proposed hospital reside within a 30-minute drive of
18 a quality hospital and approximately 90 percent within 15
19 minutes. There is not a practical need for another
20 hospital.
21 I can assure you that adding another hospital
22 in McHenry County will adversely affect existing area
23 hospitals and the patients and communities they serve.
24 Indeed, Centegra has pointed out that the addition of the

1 Mercy Hospital in Crystal Lake would have a deleterious
2 impact on patient volumes at these hospitals and would
3 result in severe financial distress. The same can be said
4 of Centegra's proposed hospital, as it would, no doubt,
5 harm existing hospitals.
6 Centegra was right. A new hospital in the
7 near proximity to hospitals not fully utilized causes
8 considerable harm. Let me give you a historical
9 perspective. In the last 30 years, this Board has approved
10 only one hospital, one new hospital. That hospital was
11 Adventist Bolingbrook Hospital. Three years after opening,
12 that hospital is only operating at 40 percent occupancy,
13 well below State standards. It's a hospital with lots of
14 empty beds. At the time of the application, Bolingbrook's
15 population was forecasted to grow even faster than McHenry
16 County's projected growth, and there were fewer nearby
17 hospitals.
18 Approving new facilities is one of the biggest
19 decisions tasked to this Board. Many complex concerns have
20 been raised, including adverse impact on quality, safety
21 net care for the vulnerable, unnecessary duplication of
22 resources and costs.
23 If there is any doubt in your mind, then you
24 shouldn't move forward. Rather, wait until the

1 State-mandated comprehensive plan or function is in place
2 and an independent impact study has been conducted. That
3 planning function was passed into law for just such a case
4 as you are voting on today.
5 Let me close where I started. Nothing adverse
6 will result from denying these projects today.
7 CHAIRMAN GALASSIE: Thank you very much.
8 MR. OURTH: Good morning. I'm Joe Ourth, and
9 as Legal Counsel for Sherman Hospital, Advocate Good
10 Shepherd Hospital, and St. Alexian Medical Center, I
11 submitted a letter, requesting that the Board defer action
12 on new hospital projects until the Comprehensive Planner
13 Rule has been fulfilled. Before you on the record is
14 literally thousands of pages of public record. You've
15 heard, you've seen many witnesses come before you, some
16 for, some against the project. For you as Board members,
17 you're accustomed to making difficult decisions, both as a
18 Board member and in your non-CON lives. Reasonable
19 decision makers want to know what's the context in which
20 you make those decisions? What's the policy context?
21 What's the goal that we're trying to achieve.
22 Two years ago when the Illinois General
23 Assembly rewrote the Illinois Planning Act, they did so
24 with two purposes in mind: One, to establish reforms and

1 to reconstitute the Board to address some of the corruption
2 issues that had plagued past boards; and, two, and equally
3 important, they established a role of a comprehensive
4 health planning function. Essentially, what the
5 Legislature thought was you create a comprehensive planning
6 function which sets policy for the state, and you then have
7 a review board that decides individual, specific projects
8 and whether that project is consistent with the overall
9 plan. As you know, the Center for Comprehensive Planning
10 still awaits implementation.
11 The decision on approving the establishment of
12 hospitals is one of the biggest decisions that this Board
13 makes. The Board's voluntary deferral of a hospital
14 approval would be prudent and, despite the applicant's
15 desire for an immediate decision, would be well within the
16 Board's powers. As Doug explained there is no urgency for
17 a decision. New hospitals are long-term decisions.
18 McHenry County residents are not deprived hospital care
19 because they can't get a bed at the present time, and if
20 the applicants truly believe that there was a great need in
21 McHenry County, they should not be afraid to wait for a
22 comprehensive plan to see that that validates that. Or
23 perhaps they anticipate that a new hospital in suburban
24 McHenry County may not be foremost in the State's health

1 plan.

2 The Planning Act here clearly contemplates a

3 comprehensive planning function to work with the Review

4 Board. That action would not only be consistent with the

5 legislative intent but a prudent planning process and

6 clearly within the Board's power.

7 CHAIRMAN GALASSIE: Thank you.

8 MS. CUTLER: Members of the Board, my name is

9 Elyse Cutler, and I'm the Vice-President for Strategic

10 Planning for the Advocate Healthcare System. In that

11 capacity, I oversee our CON work system-wide.

12 I appreciate the challenge you have before you

13 today, particularly in light of the lengthy record that has

14 been established for this project. With that challenge in

15 mind, let me reiterate and summarize the key points of the

16 opponents to this project. One, the Mercy project is

17 duplicative. Two, the Mercy project will damage other

18 hospitals' financial stability, including Good Shepherd,

19 whose financial strength allows Advocate to serve the inner

20 city. Three, the methodology used by the applicant to

21 establish bed need is flawed and relies on population

22 growth projections from before the housing market crisis.

23 Four, the most recent new hospital to be built in Illinois

24 is currently at just 40 percent capacity. Five, voting no

1 will have absolutely no negative impact on anyone's access
2 to healthcare. Six, we believe that a comprehensive state
3 health plan should be in place prior to making decisions
4 about new hospitals.
5 Also, in closing, some of you would believe
6 that today the choice is about Centegra versus Mercy. We
7 respectfully disagree with that. We would say that the
8 decision today is really about whether a new hospital is
9 needed in McHenry County, and we ask that you reflect on
10 this question, looking at the evidence and vote no.
11 Thank you.
12 CHAIRMAN GALASSIE: Thank you. Are there any
13 other members who wanted to speak publicly on this item?
14 (Pause)
15 CHAIRMAN GALASSIE: Hearing none, thank you
16 very much. We appreciate your input.
17 I would invite the applicants to the table,
18 please, from Mercy Crystal Lake Hospital.
19 (Pause)
20 MR. CONSTANTINO: Mr. Chairman, we received a
21 comment on the State Agency Report we'd like to distribute
22 at this time.
23 CHAIRMAN GALASSIE: Okay. While you folks are
24 coming up -- and we would like to ask you to sign on that

1 sheet -- we're going to ask for a Staff Agency Report.
2 MR. CONSTANTINO: Thank you, Mr. Chairman.
3 The applicants, Mercy Crystal Lake Hospital
4 and Medical Center and Mercy Alliance, are proposing a
5 128-bed hospital, 100 med/surg beds, 20 OB beds, and 8 ICU
6 beds in Crystal Lake, Illinois, in approximately 265,000
7 departmental gross square footage, at a cost of
8 approximately $200 million. The applicants are before the
9 State Board today because they propose the establishment of
10 a healthcare facility as defined by the Act.
11 The public hearing was held on this project on
12 March 18th, 2011. 52 individuals spoke in support and 68
13 individuals spoke in opposition. In addition, the State
14 agency has received a number of support and opposition
15 letters that are in your -- the packet of information that
16 was sent to all of the Board members.
17 The State Agency would like to note the
18 following: There's a calculated bed need in 2015 of 83
19 med/surg beds, 8 ICU beds and 27 OB beds. The number of
20 medical/surgical beds requested by the applicant of 100
21 exceeded the calculated need. 6 hospitals within 30
22 minutes are not at target occupancy for the service
23 provided by this project. Specifically, 4 of the 6
24 hospitals were not at target occupancy for med/surg

1 services, and no hospital within 30 minutes was at target
2 occupancy for OB services. All 6 hospitals met the target
3 occupancy for ICU services.
4 The applicants exceeded the State Board
5 standard for OB rooms by 23 departmental gross square
6 footage and exceed and the A & E fees proposed exceed the
7 State Board standard by 1.52 percent or $1,024,287.
8 Thank you, Mr. Chairman.
9 CHAIRMAN GALASSIE: Thank you, Michael.
10 MR. URSO: Mike, you handed out the comments
11 for this --
12 MR. CONSTANTINO: Yes. The letter asks the
13 State Agency Staff to include comments provided by CEO's of
14 facilities within 30 minutes, specifically Advocate Good
15 Shepherd and Sherman Hospital, comments from a U of I
16 study, and consideration that the State Board not act until
17 such time as the Comprehensive Health Planning function was
18 established as required by the Act. In addition, the
19 letter asks that we include information regarding the
20 safety net impact referenced in the letter in the SAR,
21 which states that the proposed project would have a
22 significant negative impact on other area hospitals,
23 including the loss of approximately 9,700 discharges, $144
24 million in lost revenue, and 51.5 in lost contribution

1 margin.

2 Thank you, Mr. Chairman.

3 CHAIRMAN GALASSIE: Thank you, sir.

4 (Oath given)

5 CHAIRMAN GALASSIE: Can I just ask who

6 intends to speak to the subject.

7 MR. URSO: Now, we received comments during

8 the SAR comment period in this particular application.

9 Mike just alluded to those. What this Board has the

10 discretion to do at this point in time is several things.

11 Because we have received comments between this period of

12 time, the Board can reject those comments as one of its

13 options, they can accept those comments and proceed,

14 consider and listen to this application, or they can refer

15 the matter back to Board Staff because there is something

16 in the comments that perhaps the Board thinks needs further

17 clarification or confirmation. So, because, once again, we

18 have received comments through the State Agency Report, the

19 Board needs to determine, number one, accept those comments

20 and then consider the project. Number two, reject those

21 comments, or, number three, accept those comments but they

22 need further analysis by the Staff. So that's a decision

23 that the Board has to make at this point in time, that they

24 have the discretion to make.

1 MR. EAKER: Mr. Chairman, I have a question.
2 Before the applicant makes their presentation, I would like
3 to hear more about this comprehensive plan. Is it
4 something that's in the near future? How is that proposed,
5 or is it?
6 CHAIRMAN GALASSIE: That's a very appropriate
7 question. I'll take a stab at it and then maybe David can
8 jump in.
9 The Legislature, in its infinite wisdom,
10 proposed the development of the Center for Comprehensive
11 Health Planning, which is the good news. The complication
12 is it hasn't been funded. So, as of now, unless I'm going
13 to hear something I wasn't aware of this morning, it does
14 not exist. But certainly the plan and the intention is to
15 move forward with the funding of this center. We would
16 then be working with them. Though no obligatory
17 responsibility to follow their recommendations, one would
18 certainly expect that we would have a working relationship,
19 we would want to see their recommendations.
20 MR. EAKER: As some have suggested that we
21 should be defer until this plan is done, if we -- if we
22 were to take that action, would that put pressure, so to
23 speak, for that comprehensive plan to be developed, or
24 would it be the same effect as deferring to an indefinite

1 time, delaying to an indefinite time the decision?

2 CHAIRMAN GALASSIE: I, frankly, don't know.

3 Does someone else want to try that? David?

4 MR. CARVALHO: Dave Carvalho, IDPH. And thank

5 you, Mr. Chairman. That's a very succinct summary of the

6 situation.

7 The -- when the Bill was pending, we estimated

8 that it would take, when it was up and running, somewhere

9 between a million and a million and a half dollars to fully

10 fund the Comprehensive Health Planning Center. The purpose

11 of the Center includes what you do, but goes well beyond

12 it. The purpose of the Center is to look at work force

13 needs, is to look at types of facilities that you do not

14 regulate. As you know, you have jurisdiction over only

15 what you have jurisdiction over, and so the Comprehensive

16 Planning Center was intended to be comprehensive.

17 Were we to receive funding, which we did not

18 in the current budget, which is the budget that rules for

19 the next year -- were we to receive funding next year, we

20 estimated that it would be anywhere between six months and

21 nine months to staff it up, and then it would certainly be

22 a year before it would actually develop a comprehensive

23 health plan throughout the state. So, it is not a

24 realistic expectation for there to be a comprehensive

1 health plan from a Comprehensive Health Plan Center for
2 several years.
3 MR. EAKER: Thank you.
4 CHAIRMAN GALASSIE: Thank you.
5 MS. AVERY: David, I'm sorry. I was
6 discussing something with Frank, but did you give a time
7 frame for when the Center would be up and running?
8 MR. CARVALHO: I gave a time for both the
9 Center and the plan, because once the Center is up, it will
10 take some time for it to develop a comprehensive,
11 state-wide plan at the level of detail that you would need
12 to deal with every planning area in the state.
13 Having said that, if I might, if you'd like me
14 to -- the specific issue, the interplay between the
15 Comprehensive Health Plan Center and what you do is
16 probably something else you should be aware of and thinking
17 about. The reason why the Legislature felt there was a
18 need for a Comprehensive Health Plan Center was because, I
19 think, in looking at the history of the Planning Board over
20 the last twenty years, it saw that the Planning Board
21 functioned to turn down things or approve them, but the
22 Planning Board had no roll in affirmatively going out to
23 solicit that things be done. So, for example, your
24 inventory might indicate that a particular area had a

1 particular need, but then your tools were to sit back and
2 wait for somebody to make an application to do that or not,
3 and that was the end of things. And so one of the things
4 that they wanted a Comprehensive Health Planning Center to
5 do was to develop an affirmative strategy for securing
6 unmet needs. They did not want to delegate to a
7 planning -- an agency of State Government the tools to do
8 it either. They viewed those as being prerogatives of the
9 Legislature.
10 So, the idea was the Planning Center would
11 develop a plan and then perhaps suggest to the Legislature
12 that there is an area over here that has need for more
13 surgical capacity, the marketplace doesn't seem to be
14 leading to applications for that, perhaps because of the
15 payor mix that area probably would produce, and so some
16 sort of subsidy or State capital investment or other
17 mechanism would be necessary, and then the Legislature
18 could respond to that. So, even if the Planning Center
19 were up and running, you would continue to serve the role
20 of doing -- and this is a descriptive, not a pejorative,
21 negative planning, saying yes or no to things that come up,
22 But then the Planning Center would be looking to solicit
23 things, and that's how the two would interplay.
24 CHAIRMAN GALASSIE: Thanks, David. Ready to

1 move forward?

2 MR. PENN: Mr. Chair?

3 CHAIRMAN GALASSIE: Yes.

4 MR. PENN: I'd like to make a motion that we

5 do accept this letter from Arnstein & Lehr, and I would

6 like the motion to include that we defer this application

7 and send it back to our Staff for further analysis of this

8 report of the University of Illinois College of Medicine.

9 CHAIRMAN GALASSIE: Strictly all in reference

10 to this?

11 MR. PENN: Yes. I accept this report.

12 CHAIRMAN GALASSIE: So, we are accepting the

13 report and referring it to Staff?

14 MR. PENN: And defer the application.

15 CHAIRMAN GALASSIE: The application being

16 10-089, Mercy?

17 MR. PENN: Mercy, yes.

18 CHAIRMAN GALASSIE: Can I just make a

19 suggestion we make a motion on this item in and of itself,

20 and if there is a separate motion to defer the agenda

21 item --

22 MR. PENN: Yes. Do I have to restate the

23 motion?

24 CHAIRMAN GALASSIE: You don't. The motion

1 will be to accept this document and refer it to Staff to
2 review.
3 MR. HILGENBRINK: Second.
4 CHAIRMAN GALASSIE: Thank you. Can I get a
5 roll call, please?
6 MR. ROATE: Motion made by Mr. Penn, second by
7 Mr. Hilgenbrink.
8 CHAIRMAN GALASSIE: The motion is strictly on
9 the letter that was passed out, and the motion is to accept
10 this letter and refer it to Staff for further review.
11 MS. OLSON: If we're referring it to Staff for
12 further review, does it mean we're done with this?
13 CHAIRMAN GALASSIE: It does not.
14 MR. ROATE: Dr. Burden?
15 MR. BURDEN: Yes.
16 MR. ROATE: Mr. Eaker?
17 MR. EAKER: Yes.
18 MR. ROATE: Justice Greiman?
19 MR. GREIMAN: Yes.
20 MR. ROATE: Mr. Hayes?
21 MR. HAYES: Yes.
22 MR. ROATE: Mr. Hilgenbrink?
23 MR. HILGENBRINK: Yes.
24 MR. ROATE: Ms. Olson?

1 MS. OLSON: Yes.
2 MR. ROATE: Mr. Penn?
3 MR. PENN: Yes.
4 MR. ROATE: Mr. Sewell?
5 MR. SEWELL: Yes.
6 MR. ROATE: Chairman Galassie?
7 CHAIRMAN GALASSIE: Yes.
8 MR. ROATE: That's nine votes in the
9 affirmative.
10 CHAIRMAN GALASSIE: Motion passes. Thank you
11 very much. Now moving on, there was a suggested motion.
12 Do you want to make that motion prior to the applicant's
13 presentation?
14 MR. PENN: I would.
15 MS. AVERY: Can we hear of a timeline from
16 Staff? What are we looking at? Because I know we moved
17 this item to another agenda prior to, and we're under time
18 constraints as far as from the date it was deemed complete.
19 MR. CONSTANTINO: We need to have initial
20 consideration at this meeting.
21 MS. AVERY: So we can't defer?
22 MR. CONSTANTINO: It would require a Board
23 deferral, in my opinion.
24 MR. URSO: Unless there is a Board deferral.

1 MR. CONSTANTINO: It would require a Board
2 deferral, yes.
3 CHAIRMAN GALASSIE: Now you've confused me.
4 Are we talking about the letter that was handed out, or are
5 you talking about the agenda item?
6 MR. CONSTANTINO: The agenda item, sir.
7 CHAIRMAN GALASSIE: The Board has the right
8 to approve this, defer it, reject it. So let me come back
9 to my initial point to Member Penn. You are interested in
10 making the motion?
11 MR. PENN: Yes, to defer this application.
12 CHAIRMAN GALASSIE: To defer this
13 application, with any caveats or --
14 MR. PENN: Until we get Staff's analysis of
15 this study from the University of Illinois College of
16 Medicine.
17 CHAIRMAN GALASSIE: Okay. So the motion would
18 be to defer this item pending Staff's response to the Board
19 on the University of Illinois study. Does that motion get
20 a second?
21 (Pause)
22 CHAIRMAN GALASSIE: Hearing none, motion fails
23 for lack of a second. Thank you very much.
24 And I will now refer to the applicants for

1 your presentation, please.

2 MR. KNIERY: Thank you, Mr. Chairman. Good

3 afternoon. My name is John Kniery. I'm consultant for the

4 application. With us today to my right is Mr. Javon Bea.

5 To my left is Mr. Rich Gruber. Also with us is Mr. Dan

6 Colby, Vice-President; Linas Grikis, Legal Counsel; Charles

7 Foley, CON consultant; Brad Turner, consultant; Mr. Sanford

8 Stein, Legal Counsel; Mr. Tom Jenson, Marketing Director;

9 Mr. David Kurtz, Vice-President; Mr. Joe Nemeth, CEOO of

10 Mercy Care Insurance; Ms. Sue Ripsch, Vice-President;

11 Mr. Ralph Topinka, Vice-President and General Counsel;

12 Mr. Cook, CFO and VP; and Ms. Barb Bortner, VP of

13 Marketing.

14 At this time, I would like to -- I have a

15 couple of comments on the SAR, a couple of housekeeping

16 items, potential corrections. On page 2 of the Executive

17 Summary page, under "Conclusion", it is stated that the

18 applicant does not meet State Board standard for

19 construction and contingency costs. This item was

20 corrected throughout the remainder of the SAR, but it

21 should be noted that this applicant is in conformance with

22 construction and contingency costs per square foot and that

23 that cost is within and under the State norm.

24 CHAIRMAN GALASSIE: I'm sorry. I'm just

1 going to stop you there. I'm going to apologize.
2 Could I get verification from Staff on that
3 point?
4 MR. CONSTANTINO: That is correct.
5 CHAIRMAN GALASSIE: So we are in agreement?
6 MR. CONSTANTINO: Yes.
7 CHAIRMAN GALASSIE: Thank you very much.
8 MR. KNIERY: And I spoke to the Staff also.
9 On page 15 of the State Agency Report, it stated that the
10 estimated cost for the for a lesser scope and cost
11 alternative was not provided. However, on page 115 of the
12 original application as filed, the applicant identified the
13 cost of approximately $115 million for this lesser cost and
14 scope alternative.
15 MR. CONSTANTINO: That's also correct, Dale.
16 CHAIRMAN GALASSIE: Thank you very much. So
17 we are in agreement. Appreciate you pointing that out.
18 MR. KNIERY: I'd like for Mr. Bea to make some
19 opening comments and for Mr. Gruber to be able to address
20 specifically the State Agency Report.
21 CHAIRMAN GALASSIE: Please do.
22 MR. BEA: Thank you. My name is Javon Bea.
23 I'm the President and CEO of Mercy Health Systems. We at
24 Mercy appreciate your time and commitment to this process

1 of improving healthcare for the residents of the state of
2 Illinois.
3 If I might, I'd just like to give you a little
4 brief background on myself. I was born and raised in
5 Rockford, Illinois. I attended a high school seminary in
6 Crystal Lake. Then I graduated from Northern Illinois
7 University with a Bachelor of Science, received a Masters
8 in Physical Therapy from Mayo, Master's in Hospital
9 Administration from the University of Minnesota, spent 9
10 years on the Senior Administrative Staff of the Mayo
11 Clinic, three years as Chief Operating Officer with the
12 Daughters of Charity National Health System, and 22 years
13 now as the CEO of Mercy Health System, and I am now
14 circling full back to my high school days, wanting to bring
15 a hospital to Crystal Lake, Illinois.
16 Mercy is the proud sponsor for an application
17 for a 128-bed hospital and physician medical center in
18 Crystal Lake, a community of 160,000 people without a
19 hospital and emergency services, and I'm not aware of any
20 other community in the state of Illinois this large --
21 160,000 people -- who doesn't have their own hospital and
22 emergency service. The State of Illinois bed inventory in
23 the Crystal Lake area does show a need for 8 ICU beds,
24 which we would be fulfilling through this application. It

1 shows a need of 27 OB beds, which we would be filling 20 of
2 those beds, and it does show a need of 83 medical/surgical
3 beds. We are applying in our application for 100
4 medical/surgical beds, because the State CON application
5 rules require that a minimum of 100 med/surg beds be
6 applied for.
7 Within our application, we've clearly
8 demonstrated there is a need for a hospital and emergency
9 services in the Crystal Lake area and the surrounding areas
10 of Cary, Algonquin, Lake in the Hills, and Fox River Grove,
11 who currently don't have their own hospital. Our plan
12 meets the needs of these communities in the most
13 appropriate way by offering Mercy's integrated health
14 system. Mercy has a unique, vertically-integrated health
15 system, which means we've completely integrated and aligned
16 our physician services with our hospital services and with
17 our managed care services to provide outstanding quality
18 patient care. As proof of this, three years ago, in 2008,
19 the President of the United States recognized the quality
20 of our organization and the patient care we deliver. In
21 2008, I was privileged to be honored in a ceremony in the
22 Oval Office of the White House by the President of the
23 United States and on behalf of Mercy received the
24 prestigious Malcolm Baldridge Award, which is highest

1 quality award in the country and the highest award that can
2 be given by the President of the United States. In 2008,
3 mercy was the first vertically-integrated health system in
4 the United States to have the entire health system be a
5 recipient of this award, which means that our three
6 hospitals, including Mercy Harvard Hospital in Harvard,
7 Illinois and all of our physician hospitals in Illinois,
8 were recipients of this prestigious award. In the 20-year
9 history of the Malcolm Baldridge Quality Award, over twenty
10 million requests, twenty million requests, for the
11 Baldridge criteria have been downloaded from the United
12 States Department of Commerce Malcolm Baldridge website,
13 and there have been only 87 recipients in all categories of
14 business, manufacturing, education, and healthcare. In the
15 healthcare category, there has only been 12 recipients and
16 only one vertically-integrated health system -- Mercy. So,
17 Mercy is truly a leader in quality care and organizational
18 excellence, according to United States Department of
19 Commerce and the President of the United States.
20 (Recess due to technical difficulties of court reporter.)
21 CHAIRMAN GALASSIE: Folks, I think -- I was
22 hoping to get through this agenda item, but to be quite
23 frank with you, I think it's an appropriate time to break
24 for lunch and we can do what we need to do technologically.

1 I have 11:35. We will reconvene this meeting following the
2 break about 12:35. We should be back here about 20 after,
3 20 after 1:00.
4 (Lunch recess)
5 CHAIRMAN GALASSIE: Thank you very much for
6 being timely. I will try to pull us back together here.
7 We have a quorum. We're ready to go, and I believe we were
8 just getting into your presentation. Now we have
9 technology working again. Thank you very much.
10 MR. BEA: Did you want me to continue?
11 CHAIRMAN GALASSIE: Please. Thank you.
12 MR. BEA: I just wanted to thank you for the
13 technical difficulty, because I don't know about you folks,
14 but I was getting hungry.
15 Before the break, I had talked about my
16 personal qualifications, and I was talking about the
17 quality of Mercy Health System, and I don't think there is
18 a lot more that needs to be said about the independent
19 verification of Mercy's quality and organizational
20 excellence than to be a recipient of the highest-quality
21 award in the land. Just to say, except that to achieve
22 that, we think there's been 20 million requests for the
23 Baldridge criteria, out of every business in the country
24 every form of business in 20 years, and have there only be

1 87 recipients, there's a reason for that, and that is
2 because it requires a transformation to excellence from the
3 housekeepers, dish washers, up to the neurosurgeons. And
4 so all 64 of our facilities, our 4,000-plus staff members,
5 our 400 doctors' offices all had to make that commitment to
6 excellence, and that's what we want to bring with our
7 hospital and physician medical center to crystal lake.
8 In our CON application, Mercy has chosen to
9 locate its hospital and physician medical center in the
10 most densely-populated area of McHenry County that suffers
11 from excessive traffic congestion. Everyone knows the road
12 infrastructure in Crystal Lake did not keep up with the
13 copulation growth, which really restricts people's timely
14 access to hospitals in further-away communities. The
15 Crystal Lake area is also home to the most diverse
16 population in McHenry County and has a growing geriatric
17 population in need of additional services that are more
18 accessible.
19 Accessibility is the key. We had testimony
20 come up in the public comments about, "Well, this hospital
21 is only, you know, here and there, and Sherman folks, 28
22 minutes away, or we're just so close and near." I've
23 raised six children, and I've taken several of them,
24 bleeding with gashes in their head, major cracked bones,

1 screaming in pain. I can tell you that 28 minutes and 14
2 miles would seem like an absolute eternity, not to speak of
3 the people who got up in public testimony and talked about
4 having to deliver their baby in the ambulances. And this
5 idea from the ER physician that, "Boy, if the paramedics
6 get there, everything is okay." I'm sorry, but I disagree
7 greatly with that, because paramedics are not physicians,
8 and a very common fall off a bicycle or on the ice -- a
9 very common ailment is a subdural hematoma you get with
10 breaking your little temporal bone. Minutes make the
11 difference between being a vegetable or being totally
12 normal if you can get to the ER within minutes and get the
13 blood released. So, time, accessibility is the key and
14 remember, we are putting our facility in the highest
15 concentration of elderly and low income.
16 Our hospital is going to go into the highest
17 concentration of low income in all of McHenry County, and
18 it's very difficult when people talk about -- some of the
19 folks getting up, "Well, they just kind of -- this out
20 migration, et cetera". That's great if you've got the
21 money, but when you look at the low income people, they may
22 not even have a car. They talked -- they got up and talked
23 at the public hearing about the barriers to transportation
24 to get to these hospitals and emergency rooms outside of

1 McHenry County. So it's a vulnerable population that are
2 in need of healthcare services that we are proposing to
3 serve, and the point is we're going to place our hospital
4 and medical center in the area with the highest
5 concentration of low income and elderly that have these
6 barriers and can't get to these facilities outside the
7 area, outside of McHenry County or even inside of McHenry
8 County.
9 Mercy is committed to serving the low income
10 and elderly population, as proven by our hospital in
11 Harvard, Illinois and the fact that we give over $38
12 million a year annually in charity care. But you only need
13 to look at our track record of Harvard, and I want you to
14 know that I sat before a previous CON Board, and I made a
15 commitment to the CON Board, when this critical access
16 hospital was closing, and Centegra's solution was close it
17 down, and the CON Board gave me approval for Mercy to take
18 over the ownership of this hospital that was going
19 bankrupt, insolvent, and what we have done is fulfill our
20 commitment to you folks. We put $20 million, added dozens
21 of physicians and new services to serve what is up in that
22 region the highest concentration of low income and has a
23 large Immigrant population, farm workers, migrant farm
24 workers in McHenry County. So we fulfilled our commitment

1 to you, the CON Board, in what we said we would do in
2 Harvard.
3 I also want to say that this is unlike the
4 other applicant that you're going to be hearing from,
5 because the CON Board gave the other applicant approval for
6 20 OB beds, which they never finished the project and
7 disappointed the people of Woodstock, Illinois that had
8 counted on the 20-bed women's health center and never got
9 it. So, I know that there's another application for a
10 hospital in McHenry County, and I know that you're going to
11 consider both applicants carefully. However, I just want
12 you to know that we fulfilled our commitment to you, the
13 CON Board, and we will again, if you approve our
14 application to serve 160,000 people who don't have access
15 to a hospital or emergency services.
16 The Crystal Lake location will also provide
17 better access for emergency medical responders who
18 presently face uncertainty about hospital bed availability,
19 because of these other hospitals that got up and spoke
20 about their record of emergency department bypass, and you
21 can go back and see where newspapers have covered the
22 volumes of bypassing that is going on, meaning that their
23 beds are full so often that these ambulances drive to these
24 hospitals and, because they are full, they have to send the

1 ambulance to even further hospitals, which jeopardize
2 patients. Minutes count and could mean the difference
3 between life and death. It's real cavalier to say, "We're
4 here, we can take these ambulances" but we had too many
5 people stand up and say -- there was a physician that stood
6 up at the public hearing and said, "See this sign." He
7 said, "This is what we get in the medical staff office,
8 saying it's a red light sign. Red, we're filled, yellow,
9 maybe -- excuse me. Red move on, keep sending the
10 ambulances on, send the patients to another hospital.
11 Yellow, a bed might come available. Green, we have beds."
12 That's the first time in my 36 years in healthcare I had to
13 hear about a system like that.
14 I'm going to say to you that these other
15 hospitals got up here and talked out of pure vested
16 interest. They would rather have people fight their way 14
17 miles, 28 minutes, to get access to an emergency room so
18 that they can, just in their greed, not have to work on
19 providing excellence of care and get them to choose.
20 People who can get there will choose where they want to go,
21 and they're going to choose on where they get the best,
22 excellence in care. But what I'm trying to say to you is
23 this is the highest concentration in the county of over
24 300,000 people that don't have that accessibility, the

1 highest concentration of low income and elderly.

2 The economic development impact of the project

3 would generate an estimated 800 construction-related jobs.

4 Within the first year of opening, Mercy Crystal Lake

5 Hospital will employ more than a thousand individuals, of

6 whom approximately 600 will be new jobs and join our

7 current employee, Illinois family of 87 employed

8 multi-specialty physicians and 450 employee partners. The

9 total employment impact, which is important to Illinois, of

10 Mercy Crystal Lake Hospital Medical Center grows from 1,000

11 initial jobs to 1,330 jobs within the first five years.

12 In addition to generating jobs and income, the

13 economic activity associated with our project is going to

14 generate tax revenue for the State of Illinois, for local

15 governments. The physician medical center will be paying

16 property taxes. The sales on our retail sales will be

17 subject to sales taxes, but the income taxes alone on the

18 600-plus new jobs, 950 jobs within the first five years,

19 will be generating millions of dollars of new income for

20 the State of Illinois in income taxes alone.

21 So, in summary, we've located our hospital and

22 physician medical center in an area of McHenry County that

23 has 160,000 people without a hospital or emergency care and

24 that has the highest concentration of poor and elderly

1 who -- accessibility is the key. That's the key issue,
2 accessibility. When you're poor and you're elderly, trying
3 to get to these places in a highly congested area, and
4 you've got a kid who is bleeding, and you've got a sub --
5 that's a major problem. That's what we've had hundreds of
6 people -- it became the subject of the last mayoral
7 election, because the Mayor of Crystal Lake works for
8 Centegra as Vice-President, and the people in Crystal Lake
9 are so upset because they want a hospital, but he has a
10 major conflict.
11 So, we're committed to begin this project
12 immediately upon your approval and be operational to meet
13 the healthcare community needs of these 160,000 people more
14 than four years ahead of the Centegra project. In summary,
15 Mercy has a nationally-awarded and proven track record of
16 providing the highest quality of healthcare services to a
17 unique and nationally-recognized, integrated health system
18 that aligns physicians, hospitals and managed care delivery
19 and what the current President of the United States is
20 calling for in the Affordable Care Act, accountable
21 healthcare organizations.
22 Mercy Health System, in the last month, May
23 2011 issue of "Inside Healthcare", is being described as a
24 perfect prototype of the new accountable care organization

1 that's being called for in the Affordable Care Act. Mercy
2 stands ready, upon your approval, to bring a hospital and
3 emergency services to over 160,000 residents, and I just
4 need to say that -- and I go back to the Centegra proposal,
5 that employs the Mayor at Crystal Lake, who doesn't seem to
6 want these thousand jobs in Crystal Lake or doesn't feel
7 these 160,000 people need a hospital, that you're going to
8 hear from Centegra shortly, proposing to put their hospital
9 in Huntley, a southern part of McHenry County that has
10 26,000. People by choosing this affluent area, the rich
11 area of Huntley, they're bypassing the area of greatest
12 need of Crystal Lake, 160,000 people that don't have
13 hospital emergency services and it has the highest
14 concentration of low income and need. Centegra is
15 speculating --
16 CHAIRMAN GALASSIE: I'd just ask you to keep
17 your comments regarding Mercy's application.
18 MR. BEA: Sure. Whereas our application
19 serves a current population need, without having to
20 speculate or hope for future growth, because we have
21 160,000 people now who are in need of emergency services --
22 and I do need to say, Mr. Chairman, that if these beds are
23 granted -- and it's been referred to already -- Centegra
24 will have a monopoly of 95 percent of the beds in a county

1 of over 300,000 people. So there will not be competition
2 for price. It will limit choices for healthcare workers
3 and physicians.
4 We respectfully request your favorable
5 approval, and my team and I stand ready to answer your
6 questions regarding this very worthy project.
7 To begin that discussion, I've asked Rich
8 Gruber, Mercy Vice-President, to briefly address a few
9 questions that have been raised in the State Agency Report.
10 Thank you again.
11 MR. GRUBER: Mr. Chairman, Members, thank you
12 very much for the opportunity to address our application.
13 With your permission, I'd like to spend a few
14 minutes going through the specific deviations from the
15 State norms that Staff was able to cite within our
16 application. Before I begin that, though, I do want to
17 express my appreciation to your Staff, who were
18 exceptionally professional during the entire process of
19 reviewing our application. When they requested additional
20 information, we were able to provide that to them, and they
21 are just incredibly professional, and we express our thanks
22 to them.
23 CHAIRMAN GALASSIE: We thank you for that.
24 MR. GRUBER: Specific areas that were raised

1 in the SAR that I want to address is first "Reasonableness
2 of Project Cost". This is 1120.41(c). I think it was
3 noted at one point in time during your Staff presentation
4 that our application is approximately 1.5 percent off of
5 the State standard for architectural engineering fees.
6 This is attributable directly to the method this project
7 was put together. The applicant chose to proceed with an
8 integrated project delivery system approach and is not only
9 building a hospital but also an associated physicians
10 clinic. This project delivery method requires much more
11 up-front work and collaboration to ultimately provide a
12 product that is the most reasonable to put together. In
13 our mind's eye, we thought that the notice of trade-off
14 with much lower construction costs due to the marginally
15 higher architectural engineering fees would justify us
16 being 1.5 percent over the State norm.
17 In the area of size of project, I would refer
18 you to page 15 of the State Agency Report. Of the 18
19 departments the proposed project is to serve, we're only in
20 non-compliance in two areas. Obstetrics is 23 gross square
21 feet over the State norm. OB rooms, we will be
22 all-inclusive of the patient stay, from admission to
23 discharge, and the extra square footage will, frankly,
24 allow patients and their family and support network to be

1 present throughout the entire stay. We believe that's well
2 justified for the additional 23 gross square feet it
3 represents per room.
4 The other area where we were found to be
5 outside of the State norm was Phase 1 Recovery Station,
6 where we're 81 square feet per station over the State norm.
7 This allows for glass partitions for patient privacy and,
8 frankly, patient confidentiality, and we hope you will take
9 that into consideration as you review our project.
10 The combined, overall average represents less
11 than one percent of the total hospital square footage.
12 Thus, the proposed hospital project, we believe, is in
13 substantial conformance with the criteria.
14 The next area I want to talk about very
15 briefly is planning area need, and I want to thank David
16 Carvalho for his explanation of the bed-need process and
17 how it comes together and the discretion the Board has in
18 that respect. It's very helpful information and, frankly,
19 cleared up some issues in my mind. So, thank you,
20 Mr. Carvalho.
21 The only area where a bed need is not met is
22 in the medical/surgical area, and that's met -- not met my
23 fewer than 20 beds, under the current State bed inventory.
24 In fact, it's 17 beds, to be exact. The State has

1 calculated a need for Planning Area A-10 for 8 ICU beds,
2 and we're meeting that particular need as identified by the
3 State by proposing a project that includes 8 ICU beds. The
4 State has calculated a bed need for 27 OB beds in the
5 planning area A-10, and we're proposing to meet a portion
6 of that need by proposing in our project to include 20 OB
7 beds. Nobody has opposed our project as it relates to only
8 OB or ICU. The State has calculated that there's currently
9 a need for 83 med/surg beds in planning area A-10. We
10 intend to meet that need as identified by the State by
11 proposing 100 med/surgical beds, the minimum number
12 required by Board Rules.
13 On that bed need, it has really fluctuated in
14 McHenry County and has grown rapidly since 2002. The
15 estimate in 2002 was that there was a 35-bed
16 medical/surgical and pediatric bed shortage in McHenry
17 County at that particular point in time. Between 2002 and
18 2008, the net increase in medical/surgical and pediatric
19 beds increased 518 beds. By 2020, based upon population
20 projections, the planning area A-10 need is going to be 131
21 medical/surgical and pediatric beds.
22 Different way to look at this in a slightly
23 different perspective, State occupancy target for
24 medical/surg facilities over 99 beds is 85 percent. So, 85

1 out of 100 beds are filled, and that's where you meet the
2 State's optimum in terms of performance. What's being
3 proposed by the applicant is, combined with the State's
4 target occupancy of 85, you have a need for 83 currently.
5 That's only a difference of two beds. That's only a
6 difference of two beds. The need is substantially met by
7 all three areas, med/surg, intensive care, and OB, at least
8 in our mind's eye, within the application.
9 I want to address the issue of unnecessary
10 duplication and service maldistribution. The Mercy project
11 will promote the State Board's objective by aborting
12 unnecessary duplication of services by first addressing
13 medical/surgical, pediatric bed need in the planning area
14 A-10 now and in the future. As I indicated previously,
15 I've given you the estimates of what bed need will be in
16 the future based upon the State's own numbers.
17 Second, we'll be providing primary and
18 secondary hospital care. We're a project that's a general
19 acute care hospital. We're offering community-based
20 services to a local service area surrounding the facility.
21 We're not providing tertiary care services. Work with area
22 tertiary hospitals to coordinate transfer of patients
23 requiring that level of care will be an ongoing venture on
24 our particular part.

1 Third, physician need in McHenry County, and
2 this is an important consideration, I believe, that you
3 should think seriously of. As of January 1, 2011, Mercy
4 Health System employed 76 full-time and 11 part-time
5 physicians in northern Illinois, a major contribution of
6 physician providers in that area. Mercy plans to add 45
7 additional positions in Crystal Lake, which, we believe,
8 will assist in addressing the calculated physician need in
9 McHenry County by nearly 50 physicians in March of 2010.
10 That's a projection of a need of nearly
11 physicians/specialists in McHenry County as of March 2010.
12 These physicians will play a vital role in the future
13 health of residents in McHenry County.
14 Mr. Chair, Members, in combination of these
15 factors, we're confident that this project will not lower
16 the utilization of other area providers below the occupancy
17 standards specified by the Code. Further, our data and our
18 projections indicate that this project will not lower to a
19 further extent the utilization of other area hospitals that
20 are currently -- at least during the last twelve-month
21 period -- operating below the occupancy standards. How
22 would we do that? First and foremost, we will be providing
23 services to a large and growing area that is, frankly,
24 under served physician, emergency and hospital services.

1 If you have our application in front of you, I direct your
2 attention to page 103, 103 in the application. What you're
3 going to find there is a dot matrix that demonstrates the
4 population density across McHenry County, and what you'll
5 see in the southeast corner of McHenry County is the
6 greatest density of population within McHenry County as a
7 whole. We believe that that's the right place to put our
8 hospital at this particular point in time.
9 The other issue that we want to raise is the
10 extensive out-migration of patients. From July 1, 2009
11 through June 30th, 2010, 53 percent of McHenry County
12 residents received inpatient care outside the county and 22
13 percent at hospitals outside the Defined Service Area.
14 During that same period, 70 percent of the residents from
15 the immediate service area we're proposing to serve --
16 Crystal Lake, Algonquin, Lake in the Hills, and Cary --
17 received inpatient services outside the county and 21
18 percent in hospitals outside of the service area. The
19 population growth in southern McHenry County and in
20 southeast McHenry County will continue to drive the need
21 for additional facilities. We've demonstrated that within
22 our application. Mercy's track record, a proven track
23 record, of providing higher quality, lower cost healthcare
24 services by its integrated delivery service process will

1 greatly reduce out-migration from McHenry County, and the
2 addition of the 45 multi-speciality physicians we propose
3 bringing to the area will be an attractor to McHenry County
4 residents to stay in the area as opposed to leaving the
5 area for their needed services.
6 Physician shortages. Shortages of specialty
7 physicians is one of the primary reasons that the residents
8 of McHenry County are leaving the county in order to seek
9 medical care elsewhere. We believe McHenry County has a
10 deficit of physicians. This belief on our part is
11 consistent with both the Council on Graduate Medical
12 Education and the American Medical Association, which
13 recognized a current physician shortage in the U.S. that
14 will worsen over the next several years. The operational
15 method utilized by the applicant, Mercy Health System, has
16 been implemented effectively to recruit and retain needed
17 physicians, thus helping reduce that out-migration of
18 patients from McHenry County.
19 Finally, that particular critical area of
20 service, I want to talk about Medicaid patients. In 2010,
21 McHenry County's Healthy Community Analysis sites expanding
22 numbers of Medicaid recipients within the county. In 2000,
23 the year 2000, there were 6,293 residents on Medicaid, or
24 2.4 percent of the total population. By 2009, that same

1 report shows the number grew to 25,600 residents, or 8
2 percent of the population in less than 10 years, and most
3 of that growth in Medicaid population occurred in the
4 southeast and central portions of McHenry County, the very
5 area where we have chosen to locate our facilities. By
6 2010, 30 percent of all Medicaid residents hospitalized
7 from McHenry County will live in that southeast sub area
8 that we are proposing to serve. All of these residents,
9 many without access to good transportation, must travel
10 outside the area for hospital care, because they do not
11 have a local hospital facility available, and we propose to
12 serve that population and specifically that population.
13 The next category of service where Staff found
14 us to be deficient as it related to State norms is
15 1110.3030, Clinical Service Areas Other than Categories of
16 Service. This criteria uses past physician referrals to
17 project the ability of future utilization. The State Staff
18 determined that since the historic referrals were derived
19 from the planning area, that the utilization of the
20 proposed hospital would have a negative effect on the
21 existing facilities. Okay. What this criterion does not
22 have is the ability to look at the applicant's capacity to
23 bring in new physicians into the area, which will allow
24 residents of McHenry County to stay home and receive their

1 healthcare close to home. Mercy has a plan to recruit
2 physicians and provide much-needed services to the area,
3 thus addressing that issue about migration. As previously
4 discussed with respect to the impact of healthcare reform
5 on demand, the growing patient population in McHenry
6 County, Mercy's plan to reduce the chronic out-migration
7 problem, et cetera, it is our belief that in the long run
8 the area facilities will not be adversely affected by the
9 proposed project. In fact, there are plenty of patients to
10 share among all of us.
11 In conclusion, Mercy's approach to this
12 application is in a way that looks at the Board's criteria
13 all together and, conversely, we're not trying to pick and
14 choose which criteria best fits our project. There are
15 rules that, frankly, appear to be in conflict with each
16 other which have influenced this applicant's decision in
17 what to propose. The Certificate of Need process has many
18 indicators of need. There is the utilization of area
19 facilities, the ratio of bed to population, the only
20 forward-looking indicator of need, your bed-need
21 calculation. When applying the Board's rules, other
22 indicators of need become apparent, such as the area of
23 heavy patient out-migration and beds per thousand for this
24 planning area compared to that of the state of Illinois and

1 the nation as a whole, a statistic I'll share with you.
2 In the state of Illinois and the nation as a
3 whole, there's 2.6 hospital beds for every 1,000
4 population. In McHenry County, there is 1.0 hospital beds
5 for every 1,000 members of population within that area. If
6 you use that simply as a measure, you certainly have an
7 opportunity to indicate that the bed availability within
8 McHenry County is less than what is the norm, the average
9 within the state of Illinois and the average on a
10 nationwide basis.
11 Another indicator of overall need of area
12 facilities that are closest to the proposed site, within 10
13 miles there are only three facilities, Centegra Woodstock,
14 Advocate Good Shepherd and Centegra Hospital of McHenry.
15 Combined these facilities' average occupancy is just at 84
16 percent, rounded. This equates to 2.9 beds potentially
17 under utilized in accordance with the State's optimal
18 occupancy level. In the entire 30-minute travel time
19 contour, there initially appears to be potentially a 127
20 under utilized beds based on the 2009 IDPH Facility Profile
21 on patient days, that are already two years old. However,
22 when that -- when the beds that are not set up and staffed
23 are subtracted out of the per facility profiles -- e.g.
24 licensed beds versus staff and available beds -- when

1 they're subtracted out of the profile, the potential number
2 of under utilized beds within 30 minutes is only 36, is
3 only 36 out of an inventory that, you have to attest, is
4 quite large.
5 Another area that would appear to present
6 conflicting rules is the need to serve the planning area in
7 a 30-minute contour. They can be in conflict. State Staff
8 notes on page 20 of the State Agency Report that 83 percent
9 of the expected patient volume is anticipated to come from
10 the planning area. Furthermore, patient migration is
11 normal to a degree, as all counties share borders.
12 However, McHenry County, frankly, has the highest
13 out-migration rate within the state of Illinois, and our
14 project directly speaks to that issue and I hope bring
15 those out-migrating patients back to their home for quality
16 care close to home.
17 Again, I repeat, we've approached this
18 application in a way that it looks at the Board's criteria
19 all together and, conversely, we are not trying to pick and
20 choose which criteria best fits our project. When all of
21 the criteria are viewed together, they illustrate a
22 formidable picture of need for this project, and we hope
23 you will take that into account as you give every
24 consideration to our application and hopefully move forward

1 with a project that, frankly, is the right project at the
2 right time and the right place, serving the right
3 population. We're serving 160,000 people today that don't
4 have a hospital nearby and close by and an access issue
5 that we've already demonstrated. We're not betting on the
6 come. Our population is there today. It's not there 5
7 years from now or 10 years from today... It's there today
8 and in need of service.
9 Thank you. We'll be happy to address
10 questions.
11 CHAIRMAN GALASSIE: Thank you.
12 Staff, do we have any exceptions to the
13 comments that were made there, referring to the report?
14 MR. CONSTANTINO: No, sir.
15 CHAIRMAN GALASSIE: Thank you very much.
16 I will open it up to the Board for any
17 questions you might have.
18 MR. BURDEN: Mr. Chairman, I have a question
19 for Mike.
20 On Table 5, Mercy Alliance, Inc. Safety Net
21 Information, you expressed a charity care as a percentage
22 of total net patient revenue. What about Medicaid? It's
23 expressed in numbers of patients, and the data comes from
24 Janesville. Where's the data from?

1 MR. GRUBER: This is data that is reported to
2 the IDPH for our facilities in Illinois.
3 MR. BURDEN: Well, the facilities are.
4 MR. GRUBER: Mercy Harvard Hospital and our
5 clinical facilities in the 14 communities where we have
6 multi-specialty physician clinics who do provide Medicaid
7 services as well as charity care.
8 MR. BURDEN: I'm pretty familiar with the
9 area, having had a farm in that area for about 15 years,
10 but this was back a few years ago. But I would like to
11 have an expression of Medicaid percentage, the numbers.
12 It's hard for me. We usually get it that way.
13 Mike, is there a reason why it's changed, or
14 is it something that was more appropriate for your
15 purposes?
16 MR. CONSTANTINO: Mercy Hospital -- Mercy
17 Alliance only has one hospital in the state of Illinois,
18 and that's Mercy in Harvard. What they provided us is
19 information regarding their corporate parent and the
20 Illinois facilities, as is reflected here. What you see in
21 the profile information as a personal of total revenue is
22 reference to individual hospitals.
23 MR. BURDEN: All right. I guess I'm a little
24 confused about that. I certainly am aware of several other

1 outpatient facilities.

2 MR. CONSTANTINO: There are outpatient

3 facilities. We have no jurisdiction over them.

4 MR. BURDEN: All right. Then this data is

5 confusing to me personally, but then again I recognize the

6 charity care data seems to be quite logical and reflect

7 what might be appropriate. I just have a little problem

8 with the numbers of patients as opposed to percentage of

9 patients seen. Most of the time the data we see with

10 hospitals in the past five years that I've been around here

11 has been a reflection of total rather than total numbers of

12 patients.

13 MR. CONSTANTINO: We can do that for these

14 safety net --

15 MR. BURDEN: That's all right. I don't

16 anticipate this being a game changer. I just have trouble

17 understanding why the switch.

18 MR. CONSTANTINO: I'd be happy to provide that

19 for you, Dr. Burden.

20 MR. EAKER: I would like to piggyback on

21 basically that subject of charity care. As a non-profit

22 hospital, for a new hospital, what percentage of charity

23 care are you predicting you are willing to give from this

24 hospital.

1 MR. GRUBER: I think that the best way to
2 address your question and do it in a comprehensive fashion
3 is to share with you our track record as a charity care
4 provider within the state of Illinois and then --
5 MR. EAKER: I've heard that.
6 MR. GRUBER: -- and give you the promise we'll
7 maintain that. It's always been our policy to provide
8 excellent healthcare services to the people in every
9 community where we serve, and that includes the proposed
10 facility in Crystal Lake, regardless of their ability to
11 pay. A couple of interesting things, as you put things
12 into perspective from a charity care perspective, I note
13 for you that charity care for our purposes, we begin
14 measuring at 150 percent of poverty level. The other
15 providers in the area measure it at 200 percent of poverty
16 level, which gives you a little bit of an apples to oranges
17 comparison, but, nonetheless, I think it's important to
18 note that that is a commitment that we've made across our
19 system and will continue to make here in Illinois and
20 wherever else we have facilities. Let me --
21 MR. EAKER: If I might interrupt, to get
22 specifically to my concern, throughout your presentations
23 you've talked about strategically placing this hospital in
24 an area where there is great need, where the poor people

1 are. I've heard that a lot. I'm simply asking, have you
2 put a projection to what percent of charity care for this
3 hospital you plan to give.
4 MR. GRUBER: We believe that the hospital
5 charity care level will be at least as great as the charity
6 care we provide at Mercy Harvard, in terms of a percent of
7 revenue. For example, at Mercy Harvard, our charity care
8 commitment for 2009 is at 1.5 percent of net revenue
9 compared to .9 percent for Centegra McHenry, 1.3 percent
10 for Centegra Woodstock and .6 percent for McHenry
11 Centegra's specialty hospital in Woodstock. We're assuming
12 at a minimum, through our commitment, we will be providing
13 at least 1.6 percent of net patient revenues that will be
14 allocated to a charity care category.
15 The important thing that you need to remember
16 about Mercy Health System is something I'm incredibly proud
17 to speak to. A fundamental part of our mission is our
18 commitment to community. We do everything that we do
19 driven on the basis of patient need, patient care, and part
20 of that commitment -- and it's a huge part of that
21 commitment -- is our commitment to that population that
22 frankly is a fragile population. They're in need of those
23 services.
24 MR. EAKER: I've heard that, and I just wanted

1 to know if you were willing to put a percentage projection
2 to that.
3 MR. GRUBER: We're willing to commit to at
4 least the level we provide -- and hopefully more than what
5 we provide -- at Mercy Harvard, 1.5 percent, compared to.
6 MR. EAKER: All right.
7 MR. GRUBER: And that's net patient revenue.
8 MS. OLSON: So if I can keep going on this
9 track, Table 5, is FY 10 a whole year? Because I see a
10 decrease in charity care from '08 to '09 to '10.
11 MR. GRUBER: Let me explain that, and this is
12 one of those that we grappled with. As we started pulling
13 the information together to do this, what we discovered is
14 we had an error in our calculation on the side of who we
15 were actually counting. We were counting all applicants
16 for community care or charity care assistance, all private
17 pay patients. So what we tried to do is we culled the data
18 to make it more reflective of what the reality was, and
19 that's the hard number of charity care people that we were
20 serving, and that's why you see the change, ma'am, in how
21 the numbers are reported. We believe that FY 10 is
22 probably the most accurate reflection we can possibly
23 provide to you of our commitment.
24 MS. OLSON: Thank you.

1 MR. GRUBER: You're welcome.
2 CHAIRMAN GALASSIE: Other questions?
3 MR. HAYES: I was wondering if -- you know,
4 your location is very close to the Wisconsin border, and do
5 you ever look at the amount of patients that come down and
6 serving patients from the Wisconsin area.
7 MR. GRUBER: You know, it's interesting. We
8 have a commitment to serving McHenry County, and it's a
9 commitment that is long-standing. We've been there a long
10 time. What we've discovered is two things. First, there
11 tends, first of all, to be an artificial barrier at the
12 state line that would tend to preclude patients from coming
13 across the state line to get services in Illinois, and the
14 same is true conversely with Illinois patients going into
15 Wisconsin. There just seems to be an artificial barrier.
16 One of the other interesting observations, though -- and I
17 think Mr. Nemeth spoke quite effectively to it earlier
18 today -- is insurance products have a tendency to drive
19 patients to where they are going to receive services, to a
20 certain degree, and the inability of Mercy Care to be
21 effective within McHenry County, not being able to contract
22 with existing providers in McHenry County, has really
23 precluded the ability to use insurance, at least, as a
24 mechanism to point patients in a direction for services

1 elsewhere. The interesting thing, however, is irrespective
2 of all of that being said, Mr. Vice-Chair, ultimately the
3 decision is the patient and the physician's decision to
4 make, and we believe in that and we support that.
5 CHAIRMAN GALASSIE: Member Penn, I believe,
6 had a question.
7 MR. PENN: Yes, I did. I'm sure you're aware
8 we accepted this document into our record.
9 MR. GRUBER: I am. I have not had an
10 opportunity to review that document.
11 MR. PENN: That's what I was going to ask.
12 Have you had a chance to look at this independent study
13 from the University of Illinois College of Medicine? Have
14 you had a chance to review this document? In the closing
15 comment it says, "The independent study did not report the
16 need for an additional hospital to be among healthcare
17 priorities in McHenry County." So you have not seen this.
18 MR. GRUBER: No, we have not. We would hope
19 to have that opportunity to review it at the appropriate
20 time and do our own analysis and respond appropriately at
21 the right moment.
22 MR. TURNER: And it's also important to have
23 the background of who the residents were that were
24 surveyed. Was a reasonable percentage low income or

1 elderly that are also sharing that perspective? Or is it
2 people with good insurance that have a fine ability to find
3 services and transportation to those services? We'd like
4 to understand that background.
5 MR. PENN: I appreciate your comment, and
6 that's why I asked it be referred back to Staff for further
7 analysis as well. Thank you.
8 CHAIRMAN GALASSIE: Yes, David?
9 MR. CARVALHO: When all of the Board members
10 are done with questions, I have some questions.
11 MR. BAKER: I would like to address a question
12 and kind of phrase it like this or frame it like this:
13 Supply-demand economics basically, in my limited
14 understanding, is the more supply, the lower the price
15 goes. I don't feel that that works in healthcare delivery,
16 but do you have any way of addressing the fact that $200
17 million is going to lower the cost of getting procedures
18 done?
19 MR. BEA: I just want to make an introductory
20 comment, and then Rich may have a comment. That hypothesis
21 has been put forward over the years. Except where you have
22 one institution have a monopoly. As I said in my remarks,
23 Centegra right now has 92 1/2 percent control over all beds
24 in the entire county of 300,000. If they get the

1 additional beds they'll have 95 percent. That totally
2 eliminates price competition. That eliminates the removal
3 of any insurers to come in and compete. It really limits
4 the freedom of healthcare workers. So, the issue is that
5 Centegra is able to price -- outside of the normal
6 Medicare, they're able to price in a way that they wouldn't
7 be able to if there is any competition for them.
8 MR. GRUBER: With your permission, I'd like to
9 amplify that just a little bit. As part of the public
10 record for this, we retained the services of Dr. David
11 Eisenstadt, who is a respected antitrust economist and
12 former employee of the United States Department of Justice,
13 the Antitrust Division and, frankly, he concluded in his
14 study -- which is part of the record -- the improvement to
15 competition from Mercy Crystal Lake Hospital and Medical
16 Service, he concluded that greater competition usually
17 benefits the consumer and the economy. He also concluded
18 that the more competition there is, it normally fosters at
19 least three beneficial effects, and it may be speaking
20 directly to your issue, sir. It expands consumer choice,
21 the provision of higher quality goods and services, and it
22 lowers costs and prices. In his analysis, what he found
23 was this bottom line that is really simple. After
24 extensive analysis the additional competition in McHenry

1 County created by Mercy's proposed project, if approved,
2 would result in price declines of up to 9 percent, thus
3 improving the financial ability of the residents of McHenry
4 County to obtain necessary healthcare services.
5 Conversely, he also concluded that the
6 Centegra project, if approved, would result in a virtual
7 monopoly for Centegra Health System, giving them for 436
8 out of 461 total beds in McHenry County or 94.6 percent,
9 which, in turn, will lead to increased healthcare costs for
10 the residents of McHenry County. So the choice is really
11 kind of simple. Competition tends to breed expanded
12 consumer choices, the provision of higher quality goods and
13 services being provided, and lower cost in prices, and
14 that, I believe, is part of the whole tenets of the Health
15 Planning Act in the state of Illinois. Those are goals set
16 forth in the very statutes within which you operate.
17 CHAIRMAN GALASSIE: Thank you.
18 Any questions by Board.
19 If not, Mr. Carvalho?
20 MR. CARVALHO: Thank you, Mr. Chair.
21 I'm trying to recall if Courtney and I were
22 the only ones here the last time we had a bunch of new
23 hospital applications.
24 MS. AVERY: Yes.

1 MR. CARVALHO: We were. With all of your
2 applications, obviously it's important to hear all
3 different perspectives on the information that is
4 presented, but in the case of the new hospitals, which are
5 such large investments of capital, for better or for worse
6 the prior Board appreciated me asking questions that were
7 skeptical, in order to get that information out. I'll see
8 how that goes. So, let me ask some questions that are
9 skeptical but for the purposes of illuminating the
10 information, not indicating a Department preference one way
11 or the other on the application.
12 Part of the reason why we wanted to make sure
13 the inventory information was out there was because we
14 wanted you to have an understanding of the strengths and
15 weaknesses of the inventory. With respect to this
16 particular application, let me recap the impact. The
17 overstatement of population by 10 percent from what was
18 really -- what is really there versus what was projected to
19 be there has an impact, we estimate, of reducing the
20 overall need from about the 289 beds down to 260, which
21 would reduce the unmet need from 83 down to 54, roughly.
22 You also should know that the -- as has been alluded, that
23 289 number is generated by looking at the service that
24 people receive outside of the service area and taking that

1 into account, and the contribution to the total bed need
2 for this region, due to that migration factor, as they call
3 it, is about 64 beds. So, again, of the total 289 bed need
4 in this planning area by our inventory, 64 beds of that
5 need is attributable to persons receiving care outside of
6 the planning area.
7 And the -- you know, the flip side, of course,
8 is to the extent that you build in the planning area to
9 address that need, tautologically those folks are getting
10 their care outside of the planning area, so there's a flip
11 side impact on the hospitals outside the planning area.
12 The issue of the impact of competition and the
13 CON process is the inherent conflict of the CON process.
14 Clearly, unlimited competition would involve most CON
15 process. The Legislature has made a determination that
16 there be a CON process. One of the impacts of that is that
17 if you only allow construction where there's need, you do
18 have an impact on the amount of competition. It has never
19 been part of the process that you allow construction that
20 doesn't meet your need criteria to foster competition. The
21 whole point of the CON is to cap construction at need. So
22 -- I mean, the Legislature has made that determination that
23 the CON process -- that we're a CON state.
24 In the past in these types of applications,

1 we've also heard the utilization factor is calculated based
2 on licensed beds versus staffed beds and, therefore, tends
3 to overstate the lack of utilization, because if you're
4 dividing by a larger number, you're making a smaller
5 result, and so if it's something that looks like it's 50
6 percent utilized but many of the beds aren't staffed, then
7 the beds that are staffed are being utilized at 60 percent
8 or 70 percent. But that argument overlooks the fact that
9 the unstaffed beds are, nonetheless, allowable beds and you
10 have authorized them to be staffed. At such time as the
11 demand is sufficient to staff them, they would be staffed.
12 So, in the absence of taking away those unstaffed beds,
13 allowing additional beds to be filled because there are
14 unstaffed beds elsewhere actually contributes to the over
15 supply. It doesn't work the other direction.
16 The issue of the 100 bed size was an issue
17 four or five years ago, actually, for applications, I
18 believe, in this region, and the point is you have adopted
19 a rule that says you don't want to see a hospital built
20 until the unmet need is 100, and back then, you also got
21 applicants saying, "Well, we're almost at 100, so let us
22 build." The point of the rule was wait until the need is
23 100 and then do the application, not do the application
24 before the need is 100 and then say, "Well, please overlook

1 the fact that we're not 100."

2 The safety net -- I apologize for not speaking

3 earlier when Mr. Penn had made the motion on the safety net

4 response. I had been under the impression that our Staff

5 had reviewed the materials that were supplied as part of

6 the safety net response but it simply neglected to include

7 their description in the State Agency Report. In fact, we

8 have not reviewed it, and so I do need you to know that we

9 have not reviewed that. So, the information that has been

10 alluded to in the safety net response, which presents

11 another perspective on whether there is an impact on the

12 safety net -- namely the perspective of other providers and

13 the entity that did the study -- has not been reviewed by

14 us, and so we can't make any statement to you as to whether

15 it's accurate or not.

16 In the past, there has also been the issue

17 about access and access to ER's and access to services and,

18 again, it's a balance view to draw, because the logical

19 conclusion, you'd have a hospital on every block if

20 everybody is expected to walk to their hospital and have

21 access. So, clearly, somewhere in between the access that

22 exists and the access that you would like to see is the

23 reasonable position.

24 And, finally, on the issue of charity care,

1 one of the things that you should focus on is, unlike the
2 situation that came earlier with respect to a surgical
3 center, a surgical center has no -- first off, it's not a
4 non-profit. It has no obligation to provide charity care
5 or any community benefit simply because of its non-profit,
6 charitable status, because most surgical centers do not
7 have that status. Hospitals do. But the mechanism by
8 which hospitals provide their charity care is typically
9 persons who are seen in the emergency room who do not have
10 a source of payment, and there's a Federal law that
11 requires that care be provided under those circumstances.
12 Since a surgical center has no emergency room, there is not
13 that back door entry. So when you seek a commitment with
14 respect to charity care or questions about charity care,
15 you may wish to seek the difference between affirmative
16 charity care and passive charity care. In other words, if
17 I open a hospital and I have an emergency room, I will de
18 facto be providing charity care, because some people come
19 to my emergency room who can't pay and I will be writing
20 off their bills. Affirmative charity care would be I
21 actually view a charity care as something I don't simply
22 budget for, as what is going to happen to me, but something
23 I affirmatively choose to do. How much do I set aside to
24 affirmatively reach out and provide charity care for

1 persons who may need specialty referral or other kind of
2 care that isn't typically provided in an emergency room
3 because of EMTALA obligations. So, in fact, sometimes I
4 started referring to it as uncompensated indigent care as
5 opposed to charity care, because there is really no
6 charitable impulse. It's just uncompensated, unsponsored
7 care provided as a cost of doing business.
8 So, that goes through a list of observations
9 and benefit of the history of this. Just so you know, the
10 Board has considered perhaps 8, 10 applications for new
11 hospitals over the last 8 years and approved one in
12 Bolingbrook and denied the others. But many of these
13 issues I raise today were part of the dialogue back then,
14 so I wanted to raise them today to inform you of those
15 issues. I'll stop there.
16 CHAIRMAN GALASSIE: Thank you, David.
17 Any other questions on the part of Board
18 members? I have attempted to be very gracious of the time
19 committed to this item because of the significance involved
20 in it. Does the Board --
21 MR. HILGENBRINK: Mr. Chairman, I'd like to
22 ask a question on the cost, construction cost. Has
23 anything been built into the cost of construction to
24 address ongoing operational cost? Is it a -- in terms of,

1 for example, lead design building or something with
2 sustainability to address those kind of operational costs.
3 MR. GRUBER: Let me address this in this
4 fashion: This is a project that has been on the Mercy
5 books for 7 years, waiting for that right moment to come
6 forward to serve the residents of Crystal Lake, Cary,
7 Algonquin and Lake in the Hills. We've owned the land that
8 we propose to build on for quite a number of years. We
9 have had ongoing planning activities, ongoing architectural
10 activities associated with this project for so long that
11 they've become part of a routine operating expense with how
12 we handle our Mercy budgetary issues. So, you don't see
13 those numbers appear in this project. The project numbers
14 that you see are the costs of performing the project.
15 Does that address your question, sir?
16 MR. HILGENBRINK: Not really.
17 MR. BEA: I guess maybe this will be -- but I
18 think history -- instead of our opinion, history is a
19 better guide going forward, and in our report, you'll see
20 that Mercy is one of the few systems in the country that
21 during the financial collapse of '08, '09 and '10, that
22 even though -- that continued to be extremely stable in
23 every turn in operations because of our efficiency. That's
24 how the Baldridge Award came in versus other hospitals were

1 relying on income from reserves and, of course, they lost
2 that income from reserves when the market crashed. We lost
3 income from our reserves when the market crashed, but we
4 have an amazing stability track record. I mean, the people
5 that have looked at this have said, "Wow, that's amazing".
6 And I go back to the integration between our physicians and
7 our hospital that has allowed us to maintain that kind of
8 efficiency.
9 But there are three or four questions earlier
10 about charity care, and something that is very important --
11 and Mr. Carvalho is correct, hospitals are required by
12 EMTALA to give charity care in the ER. Physicians aren't
13 required to give charity care. Something that we do with
14 all 400 of our doctors, the 87 physicians in Illinois,
15 growing to 132 physicians, is that our physicians take all
16 comers, all comers without ability to pay in the doctor's
17 offices. That is true charity care. There is no EMTALA
18 law, nothing requiring Mercy to provide charity care to
19 people walking in their offices, and the reason the doctors
20 take all is they still get paid by Mercy for providing the
21 service, even though Mercy is not getting paid. I hope
22 you're following that, but it doesn't get any better than
23 that, because people are going to doctors' offices, quite
24 frankly, before they ever show up at the hospital. But

1 when they see a sign on the wall "Charity care not
2 welcome", "Medicaid not welcome" -- that's what you have
3 here today, and a lot of it has to do with economics of
4 healthcare, et cetera. We wouldn't have to do that but we
5 do that with all 400 of our doctors. They open their doors
6 to charity care because we are still paying them.
7 And then the last comment I would like to make
8 is, there is a reason there is unstaffed beds in the same
9 community oftentimes where there are hospitals that don't
10 have unstaffed beds, and that's because of patient and
11 doctors' perceptions of the lack of patient care and the
12 lack of quality offered at those hospitals.
13 Thank you.
14 CHAIRMAN GALASSIE: Did you get an answer to
15 your question.
16 MR. HILGENBRINK: I got the information.
17 MR. GRUBER: Let me try one more time. There
18 are no operational costs included in our project, none
19 whatsoever. Does that get at the heart of your question,
20 sir?
21 MR. HILGENBRINK: Thank you.
22 MR. GRUBER: Thank you very much.
23 CHAIRMAN GALASSIE: Member Penn?
24 MR. PENN: By statute, this Board has the

1 authority to impose fines on this project if they do not
2 complete this project on time, and it's always a concern
3 for me. We look at you as being our clients. I'm not
4 comfortable imposing fines. So, my question is, have you
5 built in any type of liquidation damages to your
6 construction contract, that if this thing is not completed
7 on time, that the responsibility falls back on the
8 contractor and not the hospital.
9 MR. GRUBER: It's our anticipation that,
10 barring any litigation, we will meet the project time frame
11 that we've proposed within the application and we'll meet
12 it a hundred percent and we'll meet it within budget, and
13 we'll be pleased to come back and report to this Board
14 that, in fact, we've accomplished that objective. In terms
15 of penalty or particular interests that we would charge
16 back against a contractor who would be derelict in not
17 providing full and complete services, that is something
18 that we would certainly take a very hard and fast look at
19 if that would be a consideration that would cause you to
20 support this project, sir.
21 MR. PENN: Well, for each applicant that comes
22 forward, it's a common question I ask, if you built in some
23 type of protection, some type of safeguard, safety net
24 where you are going to absorb the cost of the fine that can

1 be passed to the contractor who did not complete his
2 project on time.
3 MR. BEA: It's a great recommendation, and
4 we'll do it. We need to know that we have approval, but I
5 love your recommendation, and we'll provide you proof that
6 we did it. We'll be taking bids for contractors, and we'll
7 make that a requirement, no problem, and it's a great
8 suggestion, and we can come back and prove to you that we
9 did that.
10 CHAIRMAN GALASSIE: I'm going to ask that the
11 Board be comfortable in moving forward and following this
12 question for a vote on this subject.
13 MS. OLSON: I just want to be sure that it's
14 your position, despite all of the other testimony we've
15 heard from all of the other hospitals in the area, that
16 your project is not going to negatively impact those other
17 health systems.
18 MR. BEA: It will not and, furthermore, the
19 citizens of Crystal Lake will back that up.
20 CHAIRMAN GALASSIE: I would like to remind
21 Members that you have an opportunity to vote in the
22 affirmative, you have an opportunity to vote in the
23 negative, you can recommend that this be deferred and/or
24 contingency, as I think Mr. Penn was suggesting, if it were

1 to move forward on this item. I think we've had ample
2 dialogue, and I ask that we move forward on this project
3 with a vote. As Frank reminds me, if you vote in the
4 negative, if you vote no, please, for the record, state a
5 reason why you are voting no. Thank you very much.
6 I would entertain a motion to approve Project
7 10-089 to establish a 128-bed hospital in Crystal Lake,
8 Illinois at the cost of approximately $2 million -- $200
9 million. That was a bargain. I need a motion.
10 MR. GREIMAN: So move.
11 CHAIRMAN GALASSIE: There is a motion. Is
12 there a second?
13 MR. BURDEN: Second.
14 CHAIRMAN GALASSIE: There is a motion and
15 second.
16 If I may ask, does Member Penn want an
17 amendment to that? Do you want a contingency on this, is
18 what I'm suggesting?
19 MR. PENN: No. thank you.
20 CHAIRMAN GALASSIE: Thank you.
21 There is a motion and a second on the floor.
22 I'll ask for a roll call vote.
23 MR. ROATE: Motion to approve Project 10-089,
24 motion made by Justice Greiman, seconded by Dr. Burden.

1 Dr. Burden?

2 MR. BURDEN: After a lengthy discussion, I'm

3 impressed with the diligence and the information that's

4 been provided by the applicant. They've worked diligently.

5 I have to comment, having been on this staff of Mercy

6 Hospital in Chicago, I'm very familiar with -- nothing to

7 do with Mercy Alliance, but I'm impressed how Sister Sheila

8 runs a safety net hospital with 38 percent Medicaid, and

9 that's part of the reason I asked questions about how you

10 handle it. It's a totally different patient demographic, I

11 understand that. I'm also very concerned when I see

12 occupancy rates in competing institutions be so low. I am

13 disappointed to see Sherman Hospital be as low as it is,

14 but I feel that, in my judgment at this moment, I would

15 have to vote no because of the reasons I've suggested. I

16 would anticipate listening to the Center for Comprehensive

17 Health Planning, when it exists more functionally, for

18 their input to help us make wiser decisions all the way

19 down the line. One new hospital in 30 years is the track

20 record. I vote, no but that shouldn't be terribly

21 shocking?

22 MR. ROATE: Mr. Eaker?

23 MR. EAKER: I have many doubts. You hinged a

24 lot of your presentation on the need for low income care

1 and that's the strategic place for that. I find 1.5
2 percent to be a very low amount for true charity care. So
3 it kind of comes down to believability. I vote no.
4 CHAIRMAN GALASSIE: Justice Greiman?
5 MR. GREIMAN: I vote aye. Just my own
6 observation, that we don't tell McDonald's you can't go in
7 there because there's a Taco Bell there. So I'm going to
8 vote aye.
9 MR. ROATE: Mr. Hayes.
10 MR. GREIMAN: And I think the presentation was
11 very well done.
12 MR. ROATE: Mr. Hayes?
13 MR. HAYES: I'd like to compliment the
14 applicant of the thoroughness of the application, as well
15 as their presentation, and I'd also like to compliment the
16 opposition that we have heard and the opposition that was
17 expressed at the public hearing. My concern here is that
18 the requested beds are in excess of the calculated need
19 that is described in the State Agency Report, and there are
20 existing facilities in the planning area operating below
21 the targeted occupancy. There are existing facilities
22 within a 30-minute, operating below the State Board's
23 target, and also the physician referrals that were
24 submitted by the applicants for the proposed project will

1 lessen the utilization of existing providers. I think with
2 healthcare reform and the state of the economy, as well as
3 the demographics that have come in from the census here,
4 and ultimately that will -- through all this process, that
5 will lead to a decline in the calculated bed need
6 ultimately. So, I'm going to vote no.
7 MR. ROATE: Mr. Hilgenbrink?
8 MR. HILGENBRINK: I'm going to have to vote no
9 based on not meeting the criteria and convincing me that
10 they have overcome those objections.
11 MR. ROATE: Ms. Olson?
12 MS. OLSON: I vote no for the same reasons
13 that Vice Chairman Hayes just eloquently outlined.
14 MR. ROATE: Mr. Penn?
15 MR. PENN: I am voting no based on what I
16 think will be a negative impact on the planning region, and
17 also giving the Staff a chance to review this independent
18 study from the University of Illinois. That's why I was
19 hoping to defer this and not bring this to a no vote, but
20 I'm voting no.
21 MR. ROATE: Mr. Sewell.
22 MR. SEWELL: I vote no. There doesn't appear
23 to be a need for the beds, and even with the uncertainty
24 we've heard with the population projections, it looks like

1 it would have a negative impact on existing hospitals.
2 MR. ROATE: Chairman Galassie?
3 CHAIRMAN GALASSIE: The chair votes no at this
4 time with comments previously made and at the same time
5 would like to commend Mercy's commitment to the community.
6 It's very clear it is significant.
7 MR. ROATE: That's one vote in the positive,
8 eight votes in the negative.
9 CHAIRMAN GALASSIE: Motion does not pass.
10 MR. URSO: You'll receive an Intent to Deny.
11 You have another opportunity to come before the Board. You
12 also have an opportunity to submit additional information.
13 Thank you.
14 CHAIRMAN GALASSIE: Thank you. Good luck to
15 you in the future.
16 We have another significant item on the agenda
17 following, and I will be making a recommendation for agenda
18 items following 090, that if there is no opposition by
19 Staff or any public opposition, that your presentation --
20 the briefer the better, to be quite honest.
21 Does the Board feel the need for a 10-minute
22 stretch? Let's take a 10-minute stretch. We will pull it
23 back at quarter to three.
24 (Recess)

1 CHAIRMAN GALASSIE: Let's call the meeting
2 back to order.
3 I will be asking -- we have public comment on
4 Item I-2, 10-090, Centegra Hospital-Huntley. If you
5 haven't signed up and intend to give comment, please do so.
6 If you find individuals before you have made similar
7 comments, please don't be redundant. The Board has seen
8 most of what's being said in writing already. So, if it's
9 new we've tried to be open and liberal with time and we
10 certainly will give you the same amount of time.
11 That having been said, Ms. Avery will read off
12 four names. We will do a joint swearing in, and then when
13 you are preparing to speak, if you will simply introduce
14 yourself.
15 (Ms. Avery identifies individuals by name.)
16 (Oath given)
17 CHAIRMAN GALASSIE: Good afternoon. Thank
18 you for your patience.
19 MR. URSO: Please sign the yellow pad.
20 CHAIRMAN GALASSIE: Thank you. Again, a
21 simple introduction, please, and then your comments.
22 MR. COOK: My name is John Cook. I am Chief
23 Financial Officer of Mercy Health System. Thank you for
24 the opportunity to comment on the Centegra-Huntley project.

1 As referenced in the report from Ziegler
2 Healthcare Finance, Centegra has realized very weak
3 historic operating performance, even with their dominant
4 market share. Centegra's weak financial performance
5 contrasts dramatically from that of Mercy's. Centegra's
6 income from operations has been declining since 2007.
7 Everyone in this room has been impacted by the
8 current recession. Healthcare organizations can no longer
9 depend on investment income to fund operations. The key to
10 success is strong operating performance. Centegra produced
11 an operative income of only $3.2 million in the most recent
12 fiscal year, after posting an operating loss of $170,000 in
13 the previous year. On a pro forma basis, the burden of
14 additional interest and depreciation associated with the
15 new hospital result in a $13.6 million operating loss.
16 This level of financial performance is consistent with the
17 matrix of organizations rated well below investment grade
18 status.
19 Centegra will be unable to access funding from
20 the tax exempt bond market. In the recently released
21 Centegra credit report, Standard and Poor stated,
22 "Maintenance of an A minus rating is predicated on
23 restoring profitability back to historical levels, and the
24 issuance of additional debt without commensurate increases

1 in revenues in earnings could negatively impact the current
2 rating."
3 Centegra will need to make significant
4 improvements in operating performance prior to going to
5 capital markets to fund this project. Centegra will be
6 pressured to leverage its dominant markets' position to
7 increase reimbursement, pushing rates higher for the
8 residents in McHenry County. Centegra cannot take on a
9 project of this size and be a financially viable
10 organization in the future.
11 Thank you.
12 CHAIRMAN GALASSIE: Thank you.
13 MR. TOPINKA: Good afternoon. My name is
14 Ralph Topinka. I'm Vice-President and General Counsel for
15 Mercy Health System. I'm hear to urge the Board to reject
16 Centegra's application for a hospital in Huntley.
17 First, I'd like to thank the Board members and
18 the Staff for their service, particularly on a long day
19 like today.
20 Centegra's project ignores the highest
21 concentration of people in the Crystal Lake area and
22 instead focuses on Huntley, a place that does not have
23 adequate public transportation services for poor people and
24 for elderly who may not be able to have their own

1 transportation. It ignores the largest concentration of
2 Medicaid under served persons in the county and in the most
3 diverse population in the planning area. The project, if
4 approved, would increase the already high concentration of
5 market power that Centegra enjoys in McHenry County.
6 In order to demonstrate a need for beds,
7 Centegra proposes to borrow beds from the Kane County
8 planning area. Also, in order to justify a need for beds,
9 Centegra is abandoning its women's health center project
10 that was approved by this Board just a few years ago.
11 Centegra proposes to build its project in an area with low
12 population of about 26,000 right now with the hope that it
13 will -- the population will increase in size to justify the
14 need for the hospital, but as we've already heard, those
15 population projections are not realistic.
16 Approving Centegra's application will
17 exacerbate the maldistribution of beds in the planning
18 area. There will be no more beds for the poor, under
19 served, and more beds for the relatively affluent area.
20 For these reasons, we urge the Board to reject the
21 application.
22 CHAIRMAN GALASSIE: Thank you.
23 MR. FLOYD: Good afternoon. I am Rick Floyd,
24 and it was good morning before, but now it's good

1 afternoon. Good afternoon.

2 Most of the comments that I intended to offer

3 today were very similar to the comments that I offered this

4 morning for the Mercy application. So, consistent with

5 Chairman Galassie's guidance, I will refrain from

6 reiterating those points. There are some individuals who

7 will be speaking on behalf of Sherman and Good Shepherd who

8 have points that are unique to this Centegra application

9 and, so you know, those folks will speak, but we have

10 withdrawn anyone who is not offering a unique, different

11 perspective on this application.

12 CHAIRMAN GALASSIE: Thank you. Appreciate

13 that.

14 MS. LAMBERT: Karen Lambert, President of

15 Advocate Good Shepherd Hospital. And as Mr. Floyd

16 indicated, my earlier comments today, I would hope you

17 would consider them as you're considering the Centegra

18 project. I feel they are absolutely applicable and the

19 concerns are indistinguishable in terms of its impact on

20 existing hospitals. I appreciate the thoughtfulness in

21 your prior application. Thank you.

22 CHAIRMAN GALASSIE: Thank you. We appreciate

23 that.

24 (Ms. Avery identifies individuals by name.)

1 (Oath given)

2 CHAIRMAN GALASSIE: Thank you very much and,

3 again, if you'll just introduce yourselves as you begin

4 your comments.

5 MR. GRUBER: Thank you very much,

6 Mr. Chairman, Members of the Board. For the sake of time,

7 I'm going to really abbreviate my remarks. Much of what I

8 intended to say has been said previously by other speakers,

9 including Mr. Topinka and Mr. Cook. So, for the sake of

10 time, I'll be very, very brief. Thank you, first of all,

11 very much for the opportunity to address this particular

12 project.

13 There's two or three keys points that I think

14 need to be brought to mind as you go forward with this

15 particular application. Centegra's project ignores the

16 160,000 people in the Crystal Lake area who are without

17 easy access to hospital services. They're proposing to

18 build in an area that has fewer than 30,000 people.

19 Frankly, it's 26,000 people, to be exact, and it's not an

20 area that is growing at the rate it used to grow. In fact,

21 their project proposes to wait a couple years before they

22 actually start construction, even if they're approved

23 today. I anticipate that the reason for that is that they

24 are betting on the come, quite obviously, that the

1 population growth will return and there will be an
2 opportunity to justify their beds on the basis of the
3 population change that they hope is going to happen in
4 McHenry County.
5 Other points that are key to this particular
6 project is the fact that if approved, Centegra would
7 further expand their monopoly to 436 out of 461 beds within
8 the A-10 Planning Area. That's more than 94 percent of the
9 beds and, frankly, as we testified previously in the --
10 during the Mercy hearing, we're firm believers that
11 competition, as laid out by David Eisenstadt, our economist
12 out of Washington, DC, former U.S. Department of Justice,
13 Antitrust Division expert, was able to indicate, that
14 competition breeds consumer choice, it breeds an
15 opportunity for lower costs, and it breeds an opportunity
16 for improvements to quality of services being provided.
17 For those reasons, I think it's important that
18 as you review this particular project you keep in mind that
19 this project, as well, does not meet the bed-need category
20 that's been established by your Board and established by
21 the State Department of Public Health. This project does
22 not meet the issue as it relates to distribution of
23 services within the region, and that's something that you
24 need to take to heart as you review this.

1 I urge you to deny the Centegra application
2 and, hopefully, in the future as you are reviewing the bed
3 needs for the McHenry County A-10 area, you look to a
4 project that is designed and intended to serve the
5 epicenter of population in McHenry County, and that's the
6 Mercy application. Thank you for your attention. Thank
7 you for your time. I hope you have a wonderful afternoon.
8 Get out of here by four o'clock.
9 CHAIRMAN GALASSIE: Thank you. It's doubtful
10 but we appreciate your optimism.
11 MS. MAYER: Good afternoon. My name is Julie
12 Mayer. I am the Director of Community Relations at
13 Advocate Good Shepherd Hospital, and today I just want to
14 highlight some findings from the 2010 McHenry County
15 Healthy Community study. These results were released in
16 April of 2011, of this year, and I mentioned the study at
17 an earlier public hearing, but I just wanted to clarify
18 some of the findings around the results. This study is
19 conducted every three years in McHenry County and it is led
20 by the McHenry County Health Department, and it is funded
21 by a group of hospitals, Centegra, Sherman, Good Shepherd,
22 as well as other not-for-profit groups, community groups,
23 and governmental groups. I am proud to serve on this
24 group's steering committee, and we -- the University of

1 Illinois School of Medicine-Rockford actually conducts this
2 study for us, and they have a research board that works
3 with them.
4 In the household survey completed by 1,100
5 McHenry County residents, availability of health services
6 was ranked the 4th highest as one of the best aspects of
7 living in McHenry County. This is counter to some other
8 documents that had been filed with the Board, and it's
9 important to note that these residents surveyed were not
10 approached to sign a petition or a form letter about a new
11 hospital, but they were simply asked, top of mind, about
12 their health status and what is important to them regarding
13 their own personal health. This result was gratifying to
14 me and to Advocate Good Shepherd Hospital, as we are always
15 seeking to serve our community needs and our health needs.
16 Through this survey McHenry County residents are saying
17 that they have readily available access to healthcare
18 services.
19 Centegra may tell you that the survey was not
20 designed to survey residents and whether or not a new
21 hospital is needed. That is true. However, answers
22 stating a need for a new hospital were also not excluded
23 from the results either. In the structure of the survey,
24 if people felt that a new hospital was necessary, they

1 could have stated so within the structure of this survey.
2 Centegra officials also have provided
3 thousands of people who wrote letters supporting the new
4 hospital application. I think we would all love to have a
5 new hospital in our neighborhood right down the street.
6 That would be great. But the fact is that there is not a
7 need for a new hospital in McHenry County. We know this
8 from the survey and we know that this is not a priority for
9 residents of McHenry County and that they are very
10 appreciative and happy with the healthcare that they are
11 getting right now. This was a scientific, unbiased survey,
12 and it was designed to identify the greatest health needs
13 in the county, and the 1,100 residents and 34 McHenry
14 County leaders surveyed deemed other health needs to be far
15 greater than another hospital.
16 I thank you for your time and thoughtfulness
17 and urge you to reject this application.
18 CHAIRMAN GALASSIE: Thank you.
19 MR. PLOSZEK: Good afternoon. I was prepared
20 to say "good morning", and you have no idea how happy I am
21 I'm not saying "good evening" to all of you.
22 CHAIRMAN GALASSIE: We share that.
23 MR. PLOSZEK: My name is Mike Ploszek, and I'm
24 the Vice-President of Community Strategy and Ambulatory

1 Services for Advocate Good Shepherd Hospital in Barrington,
2 and I should point out that our hospital is located a mere
3 4,200 feet from the McHenry County line.
4 I'm here to say that there is one simple thing
5 you need to know, and that is that the two applications,
6 Centegra Huntley and Mercy Crystal Lake, the proposals are
7 essentially the same. For the same reasons that you voted
8 to deny the Mercy application, I urge you to vote to deny
9 the Centegra application.
10 I'll just take a minute to just highlight a
11 couple of the similarities. Both proposals have the same
12 number of beds. Both are located in southern McHenry
13 County. Both are going to offer similar services, and
14 either hospital alone will increase the bed count by 50
15 percent in the county. Most important, we've heard about
16 accessibility. The residents of the proposed service area
17 already have access to several existing hospitals, and let
18 me emphasize, over 80 percent of the residents in the Mercy
19 service area are within 15 minutes of an existing hospital,
20 and over 90 percent of the residents within the Centegra
21 service area are within 15 minutes of a hospital, and, as
22 has been noted, all residents are within 30 minutes of a
23 hospital.
24 We've talked about safety net services and

1 jeopardizing quality, and I'd also like to point out that
2 both Centegra and Mercy currently have available bed
3 capacity in McHenry County operating below State occupancy
4 standards, as according to the most recent Department of
5 Public Health Annual Hospital Profile.
6 And one last point. While Centegra mentioned
7 in their application the senior population in Huntley as a
8 rationale for the project, you should know that Huntley has
9 no more senior residents than Crystal Lake does.
10 The two proposals are essentially the same. I
11 applaud your vote to deny the Mercy proposal, and given
12 that you denied that proposal and there are limited
13 differences between Mercy and Centegra, I ask and I urge
14 you to vote the same way against Centegra. Thank you.
15 CHAIRMAN GALASSIE: Thank you very much.
16 MS. REED: My name is Audrey Ramos Reed. I'm
17 a member of the Sherman Health Board of Directors. I'm
18 here to express strong opposition to Centegra's application
19 to establish a new hospital in McHenry County. For many of
20 the same reasons stated in the opposition comments to the
21 Mercy Hospital proposal, approval of the proposed Centegra
22 hospital project will very much harm our ability to combine
23 to be a safety net provider to distant franchised
24 communities we serve in Elgin, Carpentersville, South Elgin

1 and surrounding areas. Centegra sees its limited service
2 to McHenry County residents as the cornerstone of its
3 argument to build a new hospital, even those sufficient
4 capacity already exists in the area, as it has been
5 expressed by several people here. The fact that the
6 hospital project will predominantly serve residents of
7 McHenry County is a significant problem to Sherman Hospital
8 and the other safety net provider in Elgin, Provena St.
9 Joseph. While there are uninsured and minority patients in
10 McHenry County, McHenry County is predominantly white,
11 upwardly mobile and insured. As such, Centegra put forth
12 no strategic plan to maintain and enhance the provision of
13 healthcare services targeted towards these vulnerable
14 populations. To my knowledge, Centegra never responded to
15 our Hospital Safety Net Impact Analysis, which indicated
16 with more specificity than we have time here today the
17 significant negatively impact this proposal would have on
18 our facility, if the proposed Centegra hospital is
19 approved.
20 Centegra in its application incorrectly
21 equates bed need with safety net services, stating it will
22 provide safety net services by, quote, establishing a
23 hospital in a planning area that has a bed -- that has bed
24 need for these services. Importantly, bed need is a

1 calculation of community-wide need for health services,
2 while safety need pertains only to those members of the
3 community facing social, economic or geographic barriers to
4 accessing healthcare. Importantly, a new hospital will not
5 improve access to safety net services of its own accord
6 unless the access barriers are reduced.
7 Centegra identifies three census tracks within
8 McHenry County designated as medically --
9 CHAIRMAN GALASSIE: Audrey, if you can wrap
10 it up in about twenty seconds.
11 MS. REED: I will. Thank you.
12 What we wanted to say at Sherman Hospital is
13 that a -- nothing about a building of $20 million will
14 ameliorate the needs that there are in the community.
15 I thank you very much for your time and
16 consideration and strongly urge the Facilities -- the
17 Health Facilities and Services Review Board to deny
18 approval of Centegra Hospital Huntley. Thank you.
19 CHAIRMAN GALASSIE: Thank you. We appreciate
20 your comments. Moving forward we will be calling four more
21 names.
22 (Ms. Avery identifies individuals by name.)
23 (Oath given)
24 MS. DEERING: I'm Linda Deering, and I won't

1 reiterate my comments from the morning.
2 CHAIRMAN GALASSIE: Thank you. We appreciate
3 that.
4 MR. GORDON: Good afternoon. My name is Trent
5 Gordon. I'm the Director of Business Development,
6 Strategic Planning at Good Shepherd Hospital.
7 I'm opposing the proposed Centegra Hospital on
8 very simple grounds: McHenry County patients already have
9 choices when it comes to where to receive their in-patient
10 healthcare. Look at this map over my right shoulder. The
11 colored zip codes represent the zip codes in the proposed
12 Centegra service area. The colored lines represent the
13 service areas of existing hospitals in the area. As you
14 can see, the entire proposed service area of the Centegra
15 Huntley hospital is within the service areas of existing
16 hospitals, thus adversely impacting volumes and capacity at
17 these existing hospitals.
18 CHAIRMAN GALASSIE: The truth is, Trent, you
19 can probably see it, but we really can't. We've all
20 learned visuals are great if people can see them.
21 MR. GORDON: Is that somewhat better?
22 Let me give you another non-visual example.
23 90 percent of the patients in the Centegra Huntley primary
24 service area already live within 15 minutes of an existing

1 hospital, and 100 percent of the people live within 30
2 minutes of an existing hospital. To quote Centegra's State
3 Agency Report, there is no absence of services within this
4 planning area nor access limitations to the payor status or
5 evidence of restricted admission policies at existing
6 facilities in the planning area.
7 Now, in a few minutes you'll hear Centegra
8 talk about how McHenry County has the largest bed need and
9 out-migration of any planning area, and I believe this
10 claim is a little misleading. There are three hospitals
11 that are within 10 miles of McHenry County and count
12 McHenry County zip codes as part of their primary service
13 area. Good shepherd and Lake County is less than one mile
14 from McHenry County. As Mr. Ploszek said, I believe it's
15 about 4,200 feet. And Sherman hospital and Provena and St.
16 Joe's in Kane County are also within 10 miles. Indeed, in
17 looking at Centegra's own application, their defined
18 service area for the proposed hospital has three zip codes
19 in Kane County and one zip code in Lake County, and that
20 one zip code is the zip code at Barrington, which happens
21 to be where Good Shepherd is located.
22 In conclusion, while Centegra wants to make
23 out-migration as a central theme to their application, at
24 the same time they are admitting that their proposed

1 hospital will be reliant on volume from out-migration from
2 other planning areas into McHenry County. You can't have
3 it both ways. As the State Agency Report noted, there is
4 capacity at the three McHenry County hospitals. Therefore,
5 if patients are choosing to leave the county to receive
6 healthcare, it's by choice, not because they cannot be seen
7 at a nearby hospital.
8 I urge the Board to vote down this application
9 for similar reasons that they did, I think, for the earlier
10 application. Thank you.
11 CHAIRMAN GALASSIE: Thank you.
12 MR. JONES: I'm Ian Jones, and I'm a physician
13 specializing in gynecology, and I currently serve as the
14 Vice-President of Clinical Performance at Sherman Hospital.
15 I'd like to thank the Board for the opportunity to speak,
16 and what I'm going to address is some of the clinical
17 issues associated with hospital care.
18 Empty hospital beds is certainly a drain.
19 Under used medical services seriously impact the quality of
20 services provided. Numerous studies have shown that the
21 volume of specialty care and surgeries at any particular
22 hospital leads to better outcomes if the numbers are
23 greater. When a medical team performs a procedure
24 frequently, they start to get better at that task. That,

1 in turn, leads to consistent results and is reflected in
2 lives saved.
3 Sherman currently is a regional specialty
4 provider for cancer care, in conjunction with the
5 University of Chicago. Our hospital is also recognized as
6 an area leader treating heart and vascular conditions.
7 Existing facilities that serve southern McHenry residents
8 have developed their own specialties as well.
9 Quality care depends on having an appropriate
10 patient base to treat. Adding more healthcare facilities
11 to southern McHenry County would dilute patient base of the
12 outstanding facilities already serving the area. I would
13 not want to see the quality of care degraded at the expense
14 of the residents of southern McHenry, northern Kane
15 counties and Lake County because too many hospitals is
16 serving too few patient.
17 I ask the Board to reject the Centegra
18 hospital proposal, as it did the Mercy proposal, since both
19 facilities are not needed and will serve to degrade the
20 quality of care provided by the existing hospitals, since
21 the volume will now be diluted between an additional two
22 hospitals or if you -- since you've rejected the Mercy
23 proposal, an additional one hospital. Thank you very much.
24 CHAIRMAN GALASSIE: Thank you, Doctor.

1 MR. SASS: Thank you for the opportunity to
2 speak today. I'm Chuck Sass, Mayor of Huntley.
3 I'd like to thank the CEO of Mercy for saying
4 Huntley is affluent and wealthy. I would have bought a few
5 new friends today, but I couldn't afford socks.
6 There are many reasons why I believe Centegra
7 Huntley is the best project. The most important reason to
8 me is the fact that Huntley is a vibrant, growing community
9 that needs better access to better healthcare. Clearly,
10 Huntley has the most to offer. We are strategically
11 located at the crossroads of Interstate 90 and Route 47.
12 In fact, in 2012, the village will realize its ultimate
13 transportation goal of constructing a new four-way
14 interchange at Interstate 90 and 47. The interchange will
15 be a catalyst for the development of hundreds of acres.
16 Independent studies conclude that upon completion, the
17 development around the interchange will create thousands of
18 jobs. This will be in addition to the five new industrial
19 commercial projects currently under construction around the
20 I-90, Route 47 corridor.
21 Additionally, over the past decade, Huntley
22 was one of the top five fastest-growing municipalities in
23 the state with a 329 percent population increase. The
24 village's is 2000 census population was 5,730. In 2010,

1 the village's population was 24,291. Huntley is still
2 growing. This year through May, Huntley has issued permits
3 for 175 new residential units. We believe that the village
4 leads suburban Chicago in new residential units through the
5 first half of 2011. While national and state residential
6 growth has declined, even during the most challenging
7 economic times Huntley has continued to grow. Over the
8 last year and a half, the village has issued 283 permits
9 for new residential units.
10 Based on future growth projections, Huntley
11 will be the largest community in McHenry County. Huntley's
12 growth and demographic make-up validate the need for
13 improved access and healthcare services. Over 36 percent
14 of the village's population is 60 years old or older. The
15 median age in the village is 44.7, compared to 38 in
16 McHenry County.
17 On behalf of the residents of Huntley, I urge
18 you to disregard the negativity spread by the opponents of
19 the Huntley hospital project and approve Centegra's
20 proposal to bring healthcare access to thousands of under
21 served residents in southern McHenry County and northern
22 Kane County. Thank you.
23 CHAIRMAN GALASSIE: Thank you, Mr. Mayor.
24 MR. LEOPOLD: My name is Harry Leopold. I'm a

1 trustee for the Village of Huntley and a 12-year resident
2 of Sun City, Huntley. Several of my friends from Sun City
3 and I came down on a bus, and we're not affluent. Sun City
4 is an active, adult community, accounting for about 10,000
5 of the 24,000 population of Huntley. All 10,000 live
6 within four miles of the location of Centegra's proposed
7 hospital. Centegra has already made its presence known in
8 Huntley in the operation of their health-rich fitness and
9 recreation facility and an immediate care facility.
10 They've also maintained a service center in Sun City's
11 Prairie Lodge, our central activity center. Their
12 reputation for caring for the members of our community,
13 regardless of economic status, is impeccable.
14 Much has been said about population counts,
15 estimates and actuals according to the 2010 census, and
16 much more has been said about the general economic down
17 turn. But one positive measure of the economy is new
18 housing construction. In Huntley, an analysis of
19 single-family building permit new activity shows a 71
20 percent increase over the same period a year ago.
21 I urge the Illinois Health Facilities and
22 Services Review Board to approve the Centegra Huntley
23 project.
24 CHAIRMAN GALASSIE: Thank you, Mr. Leopold.

1 We appreciate your comments.

2 (Ms. Avery identifies individuals by name.)

3 (Oath given)

4 CHAIRMAN GALASSIE: Good afternoon. Welcome.

5 Start down at the right.

6 MR. LAUER: I am Bob Lauer, resident of Lake

7 in the Hills in McHenry County.

8 CHAIRMAN GALASSIE: Welcome.

9 MR. LAUER: Ladies and gentlemen of the Board,

10 good afternoon. As a concerned citizen, father of two

11 young children, and the son of a father with Parkinson's,

12 I'd like to have the best possible medical equipment and

13 physicians as close and easy as possible in time, not

14 distance. My question is are we talking about the cost of

15 a hospital, or savings of lives, improving the quality of

16 life and extending life? A lengthy conversation with an

17 uncle who is a paramedic of 30 years, and to quote the

18 doctor from Sherman ER earlier, seconds and minutes can

19 make a difference in someone's life and saving of their

20 life.

21 I'm not sure of you guys are aware of the

22 construction or congestion of McHenry County, Randall Road

23 Algonquin Road. For example, this morning it took me 20 to

24 30 minutes to go two to three miles. In our specific area,

1 we've heard about Crystal Lake, Crystal Lake, Crystal Lake.
2 McHenry County is more than just Crystal Lake. It's
3 Huntley, it's Lake in the Hills, it's Algonquin. It
4 borders Carpentersville. You can get to Marengo and
5 Hampshire with the new interchange that's proposed. Within
6 the proposed Centegra hospital, there are 6 to 10
7 elementary schools and 3 high schools.
8 Having worked on Wall Street, economics are
9 near and dear to my heart. I understand that it is tough
10 to approve big-item projects in this time of need.
11 However, as with oil going to a $110 a barrel, do we wait
12 three or four years to approve a project when there is
13 already a problem? Or do we approve it now. So, I guess I
14 would have you guys think about that.
15 Advocate Good Shepherd -- I grew up in the
16 Barrington area it's very wealthy, and those patients
17 there, a lot of them can afford to pay. I think that
18 competition the likes of, let's say, Google, Microsoft, and
19 the cost of healthcare are going to rise. I don't think
20 that this necessarily is going to increase the cost of
21 healthcare, but it could possibly reduce it and, most
22 importantly, save lives. So, I guess I urge you guys to
23 think about the children of McHenry County, the elderly of
24 McHenry County, and in the economics of the migration of

1 now in Chicago, Des Plaines, Schaumburg, but as people are
2 losing their houses, McHenry County is now, especially Lake
3 in the Hills and Huntley, a cheaper place to live and
4 you're now seeing 6 to 10 individuals, possibly, in a house
5 where it used to be two to three in the 2005 census.
6 Thank you for your support, and I urge you to
7 approve the Centegra Huntley project. Thank you.
8 CHAIRMAN GALASSIE: Thank you, Mr. Lauer.
9 MS. KENNEDY: My name is Karen Kennedy, and I
10 come to you without initials in front of or behind my name.
11 I don't wear a suit. I am one of -- I come to you to bring
12 you the face of one of the people who you would be
13 servicing by approving the hospital in Huntley.
14 I have lived in Sun City for 7 years, and the
15 impact that a new hospital would have on our community
16 would be phenomenal. It goes without saying -- and as he
17 just alluded to -- that that golden hour in the moment of
18 emergency, be it cardiac or stroke or a home accident, is a
19 no brainer. Of course that time is essential to get to a
20 hospital as soon as you can.
21 But I want to give you an understanding of
22 what our community is like, because, yes, it is a senior
23 community, but it's an active senior community. We are not
24 just a bunch of old folks, sitting in our condos, waiting

1 for the Grim Reaper to come. We have very active
2 sports-related activities. There is a large bicycle club.
3 We have over 500 people who belong to a bocce ball club.
4 There are eight tennis courts with leagues and tournaments
5 every single day of the week. We have a Stingray Swimmers
6 Club, who compete in many regional and state competitions.
7 Whisper Creek Golf Course has men's, women's and couples'
8 leagues six days a week, and there are additional leagues
9 at the Huntley Park District Pinecrest Golf Course. We
10 have 240 people in three different softball leagues in our
11 community, and they play a minimum number of 175 softball
12 games a summer. We don't just sit around and knit.
13 I think it's very important for you folks to
14 know that a large part of our community, which is 9,000,
15 are moving, playing, and loving life, but, yes, with each
16 year, we are aging and, yes, things happen. We need a
17 medical facility in Huntley that will meet our growing
18 needs as we age.
19 Another reason why I think Huntley is
20 important is because of the economic impact it would have
21 on our community. And the third reason is something that
22 hasn't been talked a lot about today. We talk about the
23 intense population in Crystal Lake and Lake in the Hills
24 and Algonquin that this hospital would service, but if

1 also, instead of looking east, you look west, there are
2 many communities to our west who are in a desert when it
3 comes to healthcare. There is Marengo, there's Union,
4 there's Hampshire, and all of the rural farm area
5 communities beyond us would look to us with a hospital that
6 would fit their needs also.
7 Lastly, but not least, another thing about
8 being in an aging population is that many of us have
9 geographical distances from our families. We lose our
10 spouses and we stop driving. For all intents and purposes,
11 there is no public transportation for us to get to physical
12 therapy appointments, chemotherapy treatments, checkups and
13 doctor's appointments. We have to rely on each other to
14 get to these vital medical things. So, for us to have a
15 full service hospital in our community would be very, very
16 helpful to this population.
17 So, in closing, for most of the arguments made
18 for both of these hospitals, yes, but the Huntley hospital
19 has particularly two critical reasons, and the first is
20 that there is a high concentration of senior population
21 within the community itself, and it also meets the needs of
22 collar communities and rural areas that would reach out to
23 this hospital, and for these reasons, I hope that you will
24 approve the Centegra hospital facility.

1 CHAIRMAN GALASSIE: Thank you, Ms. Kennedy.

2 MR. OURTH: Good afternoon. I'm Joe Ourth,

3 and I -- in the interest of time I will forego prepared

4 testimony. But Mr. Hayes raised one point that I just

5 wanted to point out and I was going to go to. It's

6 included in the response to the State Agency Report that I

7 think will be distributed to you, so I'll make it very

8 brief.

9 One of the things that he had mentioned was

10 how it was helpful to have the physician referral letters

11 in the Mercy application because it helped evaluate the

12 impact it would have on a project. One of the distinctions

13 between this project and the Centegra -- the two projects

14 is that the Centegra project did not include physician

15 referral letters, which we believe are required by your

16 Rules, and we think that would be a beneficial thing for

17 you to have, because the way those work is those physician

18 referral letters need to show not only the number that is

19 coming into the hospital but where those patients are

20 coming from, and we think that would be beneficial for you

21 in your evaluation. And we also think that, as in the case

22 with Mercy, would be the case here, that physician referral

23 letters would show one of two things, either that there is

24 not enough referrals to fill a new hospital, or that you do

1 so only at significant negative impact to existing
2 hospitals. Thank you.
3 CHAIRMAN GALASSIE: Thank you, Joe.
4 MS. CUTLER: Hi. I'm Elyse Cutler, and I'm
5 with Advocate Healthcare. Thank you for a second
6 opportunity to speak to you today.
7 Again, to summarize the points you've heard in
8 opposition to the Centegra project, one, the methodology
9 used to determine bed need for this project is flawed and
10 relies on population and growth projections from before the
11 housing crisis. Two, by disbursing volumes, this project
12 will have a negative impact on clinical quality. Three,
13 this project will have an adverse impact on the healthcare
14 safety net. Four, 90 percent of the patients in the
15 proposed hospital service area already live 15 minutes or
16 less from a hospital with capacity. And, five, in an
17 independent survey, residents identified access to
18 healthcare as one of the best things about living in
19 McHenry County.
20 Thank you for your time.
21 CHAIRMAN GALASSIE: Thank you, Elyse. We
22 appreciate your comments.
23 Has everyone who wanted to give public
24 testimony done so?

1 (Pause)

2 CHAIRMAN GALASSIE: Hearing so, I would ask

3 for any representatives from Centegra Hospital to please

4 come up, be sworn in, and introduce yourself if you're

5 going to be speaking.

6 (Pause)

7 MR. CONSTANTINO: Mr. Chairman, we have

8 received a comment on the State Agency Report. We'd like

9 to distribute that now.

10 CHAIRMAN GALASSIE: Thanks, Mike. Did you

11 want to go ahead and give your presentation?

12 MR. CONSTANTINO: Sure. That's fine. The

13 applicant, Centegra Hospital, Huntley and Centegra Health

14 System, are proposing a 128-bed acute care hospital in

15 Huntley, Illinois. This hospital will consist of 100

16 med/surg beds, 20 OB beds, 8 ICU beds. The approximate

17 gross square footage is 384,000 gross square foot, and the

18 approximate cost is $233 million.

19 The applicants are before you today because

20 the applicants are proposing the establishment of a

21 healthcare facility as defined by the Act. A public

22 hearing was held on this project February 5th, 2011. 134

23 individuals spoke in support, 85 individuals spoke in

24 opposition to the project. Once again, the State Agency

1 has received a number of letters of opposition and support
2 regarding this project.
3 I would like to note the following: There is
4 a calculated bed need of 83 med/surg beds, 8 ICU beds, 27
5 OB beds by the calendar year 2015. I would like to clear
6 up one thing. The methodology is not flawed. We have,
7 evidently, more current information. The methodology we
8 use to determine bed need is not flawed. It's something
9 we've used for 30-plus years. It's been tested in court,
10 and it's been looked at by a number of different
11 individuals. So, it is not a flawed methodology. I want
12 to make that clear to the Board.
13 Secondly, there are five hospitals within 30
14 minutes that are not at target occupancy for all services
15 proposed by this project. Specifically, three out of five
16 of the hospitals are not at target occupancy for med/surg
17 beds, and none of the beds meet our target occupancy for OB
18 beds. All hospitals meet target occupancy for ICU beds.
19 Thank you, Mr. Chairman.
20 CHAIRMAN GALASSIE: Thank you, Mike.
21 Appreciate that.
22 Before we move into your presentation, again,
23 we have a document in front of us that we need to do
24 something with. We can accept it into the recovered, we

1 can reject it, or accept this and defer the project, based
2 upon further analysis of this.
3 MR. PENN: Make a motion we accept this
4 document in our public record.
5 MR. GREIMAN: Seconded.
6 CHAIRMAN GALASSIE: There's a motion and
7 second to accept this document into public record. Roll
8 call, please.
9 MR. ROATE: Motion made by Mr. Penn, seconded
10 by Justice Greiman, called for a vote.
11 Dr. Burden?
12 MR. BURDEN: Yes.
13 MR. ROATE: Mr. Eaker?
14 MR. EAKER: Yes.
15 MR. ROATE: Justice Greiman?
16 MR. GREIMAN: Yes.
17 MR. ROATE: Mr. Hayes?
18 MR. HAYES: Yes.
19 MR. ROATE: Mr. Hilgenbrink?
20 MR. HILGENBRINK: Yes.
21 MR. ROATE: Ms. Olson?
22 MS. OLSON: Yes.
23 MR. ROATE: Mr. Penn?
24 MR. PENN: Yes.

1 MR. ROATE: Mr. Sewell?

2 MR. SEWELL: Yes.

3 MR. ROATE: Chairman Galassie?

4 CHAIRMAN GALASSIE: Yes.

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

6 affirmative.

7 CHAIRMAN GALASSIE: Motion passes. Thank you

8 very much.

9 (Oath given)

10 MR. CONSTANTINO: Mr. Chairman, could I make

11 one comment before they get started on the application.

12 CHAIRMAN GALASSIE: Sure.

13 MR. CONSTANTINO: I'd also like to make a

14 comment regarding the physician referral letters. This

15 application was based upon rapid population growth, not

16 physician referral letters. We received physician referral

17 letters in the application. There were 79 referral letters

18 in that application. It was based upon the projected

19 population growth, is how this application was presented to

20 the Staff.

21 Thank you, Mr. Chairman.

22 CHAIRMAN GALASSIE: Thank you, Mike.

23 Board members have questions for Mike they can

24 ask those in a little bit.

1 MR. EESLEY: All right. I'll get started.
2 I'll say good evening, Mr. Chairman and Members of the
3 Review Board and Staff. My name is Michael Eesley. I'm
4 the Chief Executive Officer for the applicant, Centegra
5 Health System. Seated with me today are Charie Zanck, our
6 Chair of the Centegra Board of Governors; Jason Sciarro,
7 our present Chief Operating Officer; Bob Rosenberger, our
8 Chief Financial Officer; Susan Milford, our Senior
9 Vice-President of Strategic Marketing and Planning; Aaron
10 Shepley, our General Counsel; and Dr. Ted Lorenc, our
11 Vice-President of Medical Affairs. We also have people
12 behind me that are also sworn in and able to answer
13 questions, if desired or needed, so they will be available.
14 Centegra team is excited to be here today to
15 present this historic proposal for an acute care general
16 hospital. The project is historic, because in the last 30
17 years, only one general hospital has been built in
18 Illinois. It is historic, because until today, this Board
19 has not seen a new hospital application where the need has
20 been so great. Bed need, population growth, high
21 out-migration, and other factors have never before been
22 combined to present such a compelling case for a new
23 hospital. Illinois needs a new hospital, and the need is
24 the greatest in McHenry County.

1 Centegra Hospital Huntley is supported by our
2 representatives in Springfield, municipal governments,
3 Chamber of Commerce, local charitable organizations, the
4 community college, other healthcare providers, neighbors,
5 the family and friends that live there. More than 16,000
6 letters of support are in our project file. Our board and
7 our community are very passionate about this project.
8 We took great care in designing this project
9 in conformance with State standards and preparing the
10 application in conformance with these rules. We are
11 pleased to be here today to present Centegra Huntley for
12 your review.
13 The story of Centegra Health System is one
14 steeped in history. It is a story about a community,
15 service and collaboration and growth. The story began in
16 1914, when Dr. Hyde West opened his home in Woodstock
17 Public Hospital and established and eventually became
18 Memorial Medical Center of Woodstock. Forty-two years
19 later, a group of doctors founded McHenry Hospital in the
20 basement of a medical clinic along the Fox River. In 1984,
21 after experiencing tremendous growth, McHenry Hospital
22 changed its name to Illinois -- Northern Illinois Medical
23 Center and relocated on Bull Valley Road in McHenry. By
24 1996, the boards of Memorial Medical Center and Northern

1 Illinois Medical Center realized the best way to serve the
2 community was together, so they joined forces and
3 established Centegra Health System.
4 Since that time, under the guidance and
5 direction of the Board of Governors, who live and breathe
6 in the community we serve, Centegra Health System has
7 continued to collectively focus our energy exclusively on
8 meeting the healthcare and wellness needs of our community
9 through an integrated delivery model. For Centegra the
10 focus is upon market -- is not upon market share and margin
11 as much as it is upon providing the need and services along
12 a full continuum for people who cannot get them anywhere
13 else. For example, Centegra Health System is the one and
14 only provider of inpatient behavioral health services in
15 the entire A-10 Planning Area. We have been providing
16 these services for years, because that is what our
17 community needs and that is what our community will
18 receive.
19 As the needs of our community have grown, we
20 have grown with them. As the healthcare has evolved, we
21 have evolved, and that is one of the reasons this project
22 is before you today. Every step Centegra has taken has
23 been a part of a carefully-crafted plan, designed to meet
24 the needs of the community and to comply with the rules of

1 the Illinois Health Facilities Service Review Board. It is
2 worth noting that Centegra Health System Board has been
3 unbending in its insistence that the projects submitted by
4 our organization be in compliance with State Review
5 standards. We have remained on our sidelines, planning and
6 waiting for the need to arise, even while we've seen others
7 expand with facilities that have no need or no required
8 need.
9 The project before you is a product of a
10 planned process which has a foundation, nearly a hundred
11 years of acquired knowledge about our community and its
12 needs. In 2004, there was no need for a new hospital in
13 McHenry County. State calculations actually reflected an
14 excess of 53 beds, medical/surgical beds, at that time.
15 However, growth projections pointed to possibly future
16 need, a need which has now materialized. Based upon the
17 projections for growth that extend as far forward as 2020,
18 we determined to extend the new hospital that would be
19 needed in McHenry County. The need would be the greatest
20 in the southern part of the county. This has been
21 determined through our knowledge of that community.
22 Consistent with our belief, in August 2006 we
23 purchased the property upon which the proposed location of
24 Centegra Hospital Huntley would be. In total, it was 110

1 acres. Thereafter, in an effort to start slowly, we sought
2 to obtain a CON to approve construction for an immediate
3 care and imaging center, with some of the Chicago area's
4 most advanced services. In addition to that beginning, we
5 recruited physicians, and we also constructed a
6 state-of-the art fitness center. Approval for the project
7 was received in June 2007 and was completed in 2009,
8 meaning while we were moving forward with plans to expand
9 the campus of Centegra Hospital Woodstock. We received a
10 CON for the approval of that project in 2008, a date that
11 was, unfortunately, at the leading edge of the worst
12 economic crisis the United States has seen since the Great
13 Depression. That crisis forced us and many other
14 healthcare providers to rethink our plans. We did that by
15 embarking on a comprehensive review of our market and
16 master plan and, in doing so, we concluded, for the reasons
17 which will follow, the better course of action for the
18 community would be to construct a new hospital in Huntley.
19 One question that we have been asked is why
20 Huntley? In fact, as we crystallized our plans for the
21 project, Centegra board members were the ones that asked
22 the question. The answer was simple. But first let's
23 discuss Illinois and McHenry County. The State of Illinois
24 is fifth largest in the Union, with a population of nearly

1 13 million people. Yet it has only approved the
2 construction of one new general acute care hospital in the
3 last 30 years. The boundaries of McHenry County and
4 Planning Area A are the same. According to the State
5 formula, this planning area has a calculated bed need of 83
6 medical/surgical beds, 8 intensive care beds, 27 OB beds.
7 There is a bed need. This calculated bed need begs another
8 question: If not now in McHenry County, when and where
9 would a new hospital ever be approved in Illinois?
10 Considering that the State criteria McHenry
11 County has, one, the highest medical/surgical bed need
12 along the 40 statewide planning areas; two, the second
13 highest projected population growth in the entire state;
14 three, the highest percentage of net out-migration in
15 Region A, which consists of Chicago and eight collared
16 communities and third highest in the state; four, the
17 second highest medical/surgical utilization among all
18 statewide claiming areas; and, five, the lowest
19 bed-to-population ratio among all statewide claiming areas.
20 The need for a hospital here and now is beyond debate.
21 Within McHenry County and A-10 Planning Area,
22 Huntley is the best possible location to meet the
23 calculated need because, one, there are no existing
24 hospitals in southern McHenry County area; two, Huntley and

1 the surrounding communities have been and remain among the
2 fastest growing in the state and Chicago metropolitan area,
3 and Huntley continues to grow in spite of the poor economy;
4 number three, combination of the lack of hospital in
5 southern McHenry County and the rapid population growth
6 mean that a new hospital in Huntley will have at least --
7 the least impact on existing facilities; four, southern
8 McHenry County includes some of the county's largest
9 population centers, including Huntley, Algonquin, Lake in
10 the Hills and southern Crystal Lake; five, the service area
11 of Centegra Hospital Huntley includes northern Kane County,
12 Planning Area A-11, which has its own calculated bed need
13 of 61 medical/surgical beds. As noted in the State Agency
14 Report, Planning Area A-10 and A-11 are rated first and
15 second in the calculated bed need in the state and are
16 among the only three planning areas in Illinois with any
17 bed need at all. Six, Centegra Huntley will serve
18 federally-designated, medically underserved population,
19 MUPS, in both Planning Area A-10, McHenry County, and
20 Planning Area A-11, northern Kane County, and will serve
21 health professional shortage areas in Planning Area A-11.
22 Seven, Huntley is the location of Del Webb Sun City, as
23 active-living community, which you've heard, of more than
24 9,000 seniors. Quick access to hospital services,

1 including emergency services, is imperative for the senior
2 population.
3 Another question that has arisen in connection
4 with the project is why now? Why not wait until additional
5 17 beds are needed? The answer, if we are to wait, that
6 would be called reacting rather than planning. To wait
7 would require us to ignore the need that exists right now,
8 and it would deprive our residents of the primary service
9 area ready access to healthcare that is not currently
10 available. This would be contrary to our values and
11 contrary to the best practice of the healthcare industry
12 and is contrary to the intent of the Illinois Health
13 Facilities Act. In fact, by the time Centegra Hospital is
14 up and running for two years allowed under State standards,
15 the additional 17 beds will be needed.
16 Moving forward with this project now will
17 ensure access to care for people who need it when they need
18 it. Waiting will ensure that we will always be behind the
19 growth curve. Above and beyond the fact that by 2018 there
20 will be a need for at least 100 medical/surgical beds the
21 CON rules also allows for a variance to bed-need
22 requirements for rapid population growth, and this project
23 is eligible for that variance, and the State Agency Report
24 confirms that Centegra has submitted documentation to

1 support this variance.

2 Healthcare reform provides the final

3 compelling reason for the Board's approval of Centegra

4 Hospital Huntley. The provisions in the healthcare reform

5 are scheduled for full-scale implementation in 2013. It is

6 widely recognized that the healthcare reform is increased

7 demand for access to care as people who were formerly

8 uninsured become insured and increase the responsibility on

9 providers. Centegra Hospital Huntley will be used as a

10 shoulder to add to those responsibilities and the needs of

11 the community, as we have since 1914.

12 On June 14th, 2011 the State issued the State

13 Agency Report pertaining to the project. Of the 17 review

14 criteria, the State found only 3 did not appear to be in

15 conformance with the criteria. I'd like to take the

16 opportunity to briefly address those findings, because we

17 believe, as demonstrated by our submission, the project

18 does, in fact, substantially comply with the State

19 standards.

20 The negative findings arise from consideration

21 of bed need and the impact on other providers. In regard

22 to bed need, State Agency Report acknowledges the need for

23 all of the requested beds except for 17 medical/surgical

24 beds. Concerning impact on other providers, the report

1 notes that other providers within 30 to 45 minutes are
2 operating below targeted occupancy rates and on that basis
3 concludes that it would appear that the proposed hospital
4 would impact other providers. In response to these
5 findings, we would make the following observations: First,
6 the bed need in Planning Area A-10 is established by the
7 State's own calculations. The additional 17
8 medical/surgical beds we are seeking are justified by the
9 fact that the Planning Area A-10 is the second fastest
10 growing planning area in the state, and as noted in the
11 State Staff Report, we have submitted documentation
12 justifying the 17 beds, in accordance with the Board's
13 criteria on rapid population growth. The additional beds
14 are also justified by the fact that the primary service
15 area for Centegra Hospital Huntley includes northern Kane
16 County Planning Area A-11, The planning area in Illinois
17 that's second highest in bed need.
18 Second, although the current utilization rates
19 of existing providers are irrelevant consideration, those
20 rates are not a substitute for and do nothing to diminish
21 the calculated bed need for the Planning Area A-10 and
22 A-11. In fact, use rates of migration and population
23 growth are all inputs in a way the formula was calculated,
24 identifying current need. Allowing utilization rates to

1 trump need could effectively stop any new replacement
2 hospital from ever being built in Illinois and thus far
3 falling fall short from the Planning Act goal to provide
4 residents access to quality healthcare.
5 Most importantly, the rapid population growth
6 in the planning area, which is expected to continue, will
7 support healthy utilization rates for all providers, not
8 just Centegra Hospital Huntley. The mission of Centegra
9 Health System is to provide quality healthcare services
10 with innovative and responsible use of resources and to
11 promote wellness of greater McHenry County area. Our
12 organization has been engaged in this mission since
13 Dr. West converted his home into the first hospital in
14 1914, and Centegra Hospital Huntley is another critical
15 step in our continued commitment to this mission. This
16 proposed hospital substantially complies with State
17 standards, just as many of our projects in the past have.
18 There is an identified need for this hospital now and the
19 need will only become greater in the future. The community
20 reserve has embraced this project as no project before has
21 ever been embraced.
22 For all of these reasons, we are asking the
23 Health Facilities Planning Board to approve Project 10-090,
24 Centegra Hospital Huntley, and we will be happy to address

1 questions.

2 At this point I'm going to turn it to Aaron

3 Shepley, General Counsel, to address a couple of items.

4 CHAIRMAN GALASSIE: Thank you.

5 MR. SHEPLEY: Thank you, Mr. Chairman,

6 Mr. Eesley, Members of the State's Staff and Board.

7 I wanted to take this opportunity to focus a

8 little more specifically on the few areas where the

9 findings on the State Agency Report were negative. There

10 were three. Before I do that -- and I know that

11 Mr. Carvalho did a very nice job of explaining this

12 earlier, but we've heard a lot of things today and over the

13 course of this project about monopoly, and I think that

14 Mr. Carvalho put it in its correct perspective relative to

15 the function of the Planning Board. But I think we need to

16 make clear in the record that Centegra Health System does

17 not have a monopoly in effect, and we don't have a monopoly

18 in fact, and the approval of this hospital, even if it were

19 a relevant consideration -- and it's not -- would not

20 create a monopoly where one previously didn't exist. The

21 fact of the matter is that our market share in our Planning

22 Area and elsewhere is 48 percent. That is not consistent

23 with what everybody popularly believes as a monopoly. The

24 fact of the matter is that more than 50 percent of the

1 people who live in our county, the area where this supposed
2 monopoly exists out-migrate to other counties to receive
3 their care.
4 The other, more practical side of things is
5 that as everyone on the Board is probably very well aware,
6 the method for healthcare reimbursement is highly dependent
7 upon the Government. Approximately 55 to 60 percent of the
8 reimbursement or the patients that we serve are Medicare
9 and Medicaid, and I think we can all agree that Centegra
10 Health System does not tell the Government how much they're
11 going to pay us. They tell us what they'll pay us, and
12 that's what they tell every other healthcare provider.
13 This would be inconsistent with a monopoly in effect.
14 Another 5 percent of the patients that we serve, who are
15 self-paid patients, we have limited reimbursement from. We
16 don't tell them what we're -- dictate in terms to them
17 either. So I just wanted to clarify that for the record.
18 I degree with Mr. Carvalho's statement earlier that the
19 whole discussion about monopoly is inconsistent with the
20 CON process, but after you hear the same comments a number
21 of times, at some point you have to respond.
22 Next, I wanted to briefly talk about the
23 findings that we had in the State Agency Report that were
24 negative findings. The number one finding -- first of all,

1 let's start with the positive. The State Agency Report
2 absolutely confirmed the need for the OB beds that we're
3 asking for. In fact the need for OB beds is listed as 27
4 and we're asking for 20. The need for ICU beds is 8 and
5 we're asking for 8. So, the limited finding that was of a
6 negative nature from the State Agency Report focused on the
7 17 additional beds.
8 We have submitted support data through our
9 report and through all of our submissions -- and this is
10 confirmed in the State Agency Report -- to justify this
11 Board allowing us those additional 17 beds on the following
12 bases: One -- and this is first and foremost -- there is a
13 recognized variance within the State standards for rapid
14 population growth. We have submitted the data, and the
15 State Agency Report confirms the submission of this data at
16 page 23 of 35. We have submitted the data to justify our
17 eligibility for that variance. So that's number one
18 justification for the 17 additional beds.
19 Number two, we have extrapolated the
20 population projections going forward beyond 2015, because,
21 as Mr. Carvalho pointed out, 2015 is the stopping point.
22 Our project will have completed it's second full year of
23 operation in 2018. By that time, if you carry forward --
24 based on the same data that the State uses in its formula,

1 if you carry forward those population projections, there
2 will be a need for 104 medical/surgical beds, which will
3 put us within the parameters that we need to be in.
4 Number three -- and I think this is by far one
5 that cannot be overlooked -- we are exactly two miles from
6 Planning Area A-11 Planning Area A-11 has a calculated bed
7 need of 61 beds. They are the -- they are one of three
8 planning areas, including ours, in the whole state of
9 Illinois that have any bed need at all, as Mr. Eesley
10 pointed out. When you calculate the fact that we will be
11 serving that population in northern Kane County where there
12 is this bed need, that is the third justification for those
13 additional beds.
14 Another thing that was briefly touched on --
15 and I think a lot of us are scratching our heads, wondering
16 what exactly the impact of health reform will be on
17 everyone. But one thing that I think we all agree on is
18 that to the extent that healthcare reform is carried
19 forward, there will be more insured people, and that will
20 mean there will be more people who will need access to
21 care, and that is not a part of the formula, and I'm not
22 suggesting that it should be. I agree with the formula,
23 and we based all of our decisions on that formula, but I
24 think it is a relevant consideration. It will increase the

1 need for hospital services, not decrease them.
2 Second thing I wanted to focus on in the State
3 Agency Report are the utilization and the occupancy
4 projections that we have. As is noted in the State Agency
5 Report, two of the three negative findings are based on the
6 fact that there are other providers within Planning Area
7 A-10, or within 30 minutes, that are operating below target
8 occupancy. First, two of those facilities are our
9 facilities, and I think on behalf of myself, Mr.
10 Rosenberger our entire executive team, Mr. Eesley, we have
11 no intention of taking actions that would be contrary to
12 the well-being of those organizations. The second point is
13 that of the remaining three, two of them are at target
14 occupancy. That would be Advocate and Provena St. Joseph.
15 The third player that is not at target occupancy is
16 Sherman. Sherman has been below target occupancy -- and I
17 think Dr. Burden recognized this a little bit earlier.
18 They have been below target occupancy since at least 2002.
19 Furthermore -- and this is the final point
20 before I hand it off -- the fact of the matter is that we
21 did a very careful analysis. We brought in Deloitte to
22 provide us with the impact analysis in order to go forward
23 with this. We have no interest in harming other providers.
24 We have every interest in serving the people that are

1 living in the community who are currently under served.
2 When Deloitte gave us their findings -- and we pay them
3 whether they give us findings we want too hear or don't.
4 When they gave us our findings, they confirmed for us that
5 we will not have a material impact on the other providers
6 in the area, and they further confirmed that because of the
7 projected population growth -- and as you heard from Mayor
8 Sass about how well they're doing in Huntley. Because of
9 the projected population growth, everyone's utilization is
10 going to increase, and if you don't believe me, just look
11 back to the last hospital project that was approved by this
12 Board which was Bolingbrook, Adventist Bolingbrook
13 Hospital. There were five objectors to that hospital. All
14 five of them were below target occupancy, and they made
15 exactly the same argument that have been made here. After
16 the construction of that project, three out of five of
17 those organizations actually had their occupancy rates
18 improve, and that's a good thing. It has to do with
19 population growth. The two that did not have theirs
20 improved, only marginal decline.
21 So, in sum, I would say that those State --
22 the overwhelming tenor of the State Agency Report is
23 positive. We are here to serve the community. The three
24 negative findings that we have, we have provided the

1 information to support it. And I'd like to turn it over to
2 Susan Milford, our Director of Strategic Marketing and
3 Planning, to talk a little bit about the population.
4 MS. MILFORD: Good afternoon. Thank you so
5 much for your time today.
6 I do want to talk a little bit about the
7 variance that we use for rapid population growth to show
8 you that we are able to meet your standard, which is 85
9 percent utilization after two years of operation of our
10 hospital in Huntley, and we've used the same methodology
11 that Mr. Carvalho shared with you, and as Aaron just said,
12 we will have a 104-bed need, medical/surgical bed need, at
13 that time.
14 But we did a second piece. In addition to
15 doing the State methodology, you have the Deloitte & Touche
16 analysis in your packet. Deloitte took a look at the
17 service area. So, we defined the service area of this
18 hospital. So, a normal way that planners look at hospital
19 service areas is where will 75 percent of the patients come
20 from? We looked at that. There is a map in our CON
21 application on page 332 that shows you the identification
22 of the primary service area and the secondary service area.
23 It contains 16 zip codes. This is an area that is not
24 currently served by a close hospital. This is an area

1 that, when we look at the projection populations with the
2 Deloitte analysis, will meet that utilization outlook.
3 I think one of the points that Mr. Carvalho
4 made was that the 2010 census came out and McHenry County
5 population didn't meet what was projected. So, yes, it did
6 have that 9 percent decrease. However, the Deloitte
7 analysis used Claritas, which is an accepted methodology
8 for population growth, and Claritas adjusts every year,
9 even through the economic down turn, and, in fact, the
10 growth rate, the annual growth rate slowed down by 30
11 percent. So, the census did slow down, but we adjusted for
12 that slow-down. So, with the population growth, we have --
13 Deloitte & Touche backing up, in this service area we will
14 meet the utilization requirement that the CON rules state.
15 The other piece that's important to this
16 project to think about is we've been responsibly developing
17 for the growth in this area. As Mr. Eesley said, this is
18 not an area that we just sort of Johnny-came-lately decided
19 to serve. We've been serving it for nearly 100 years and
20 noticed many years ago where the growth of McHenry County
21 was happening, and it really is in that southern area,
22 which is why we purchased the land. And we didn't propose
23 to build a hospital right away. We recruited physicians,
24 we put them in lease space, we came to you to get approval

1 on an outpatient health services facility, which you
2 approved. And we've looked at the patients that are using
3 our outpatient services right now, and they're from this
4 market area that we've identified for the new hospital.
5 So, the time is now for us to take that next
6 step for the community, and we want you to understand that
7 we've really diligently looked at this, not only with your
8 rules but with the variance for population growth that is
9 allowed in your rules.
10 CHAIRMAN GALASSIE: Thank you.
11 Any other comments.
12 (Pause).
13 CHAIRMAN GALASSIE: Hearing none, thank you
14 very much. I'm going to open it up to the Board for
15 questions.
16 MR. SEWELL: Could I ask the Staff or the
17 ex-officio members to speak to this variance on rapid
18 population growth?
19 MR. CONSTANTINO: In our rules, we have what
20 is called "rapid population growth" criteria. It's under
21 med/surg criteria, and I've got it up here on my screen.
22 And we allow for a projection using rapid population
23 growth, if it appears reasonable, and in this case, the
24 applicants were able to demonstrate that they had -- this

1 is from the Deloitte study -- 9 1/2 percent increase in the
2 primary service market area and 6.2 in the secondary market
3 area by 2015. We believed that was reasonable, and we
4 believe that is within the rapid population projection as
5 provided to us.
6 MR. SEWELL: This is a population projection
7 for 2015?
8 MR. CONSTANTINO: Yes.
9 MR. SEWELL: So it's just a phenomena of the
10 Health Service Area?
11 MR. CONSTANTINO: A-10, McHenry County.
12 MR. SEWELL: It has nothing to do who the
13 applicant might be? It's just that this applicant asks for
14 you to look into that?
15 MR. CONSTANTINO: They provided us with a
16 study from Deloitte & Touche.
17 MR. SEWELL: And you've concluded it's your
18 opinion that it was met?
19 MR. CONSTANTINO: Yes, sir.
20 MR. CARVALHO: Mr. Chair, could I address
21 that, too.
22 Mike, in the analysis, does it start from the
23 10 percent lower number that the census of 2010 indicates
24 for McHenry, or does it work off of the 10 percent higher

1 number that the State's projections developed in 2006?
2 MR. CONSTANTINO: Dave, I don't know that
3 answer without looking at the document. I'd have to take
4 some time to look at the document. I don't have that
5 answer right in front of me.
6 MR. CARVALHO: Sure.
7 MR. CONSTANTINO: Maybe the applicant could
8 answer that for you.
9 MR. CARVALHO: I guess what I'm trying to
10 figure out is how did we conclude that it met the variance
11 if we don't know the answer to that?
12 MR. CONSTANTINO: I don't have that document
13 in front of me. I'll be happy to look it up and let you
14 know. I'd be happy to do that. Would you like for me to
15 do that?
16 MR. CARVALHO: Yeah, although they look like
17 they're ready to do so, too.
18 MS. MILFORD: We have our representative from
19 Deloitte & Touche here, who could also talk to this
20 analysis.
21 MR. PIEKARZ: My name is Lee Piekarz. We used
22 the actual numbers of utilization in 2009 and '10 to run
23 forward. So, Claritas has adjusted those population growth
24 rates down from 2008 to 2010, taking a 30 percent decline.

1 What we did was took actual patient population by zip code,
2 by DRG, by age cohort, and looked the slower growth rate to
3 project what it would be in (inaudible), both for this
4 project as well as we looked at the impact to the other
5 providers in the area.
6 MR. CARVALHO: You projected utilization and
7 population as well?
8 MR. PIEKARZ: Population as a part of --
9 Claritas adjusted those numbers. We looked at each age
10 cohort between 2010 and 2015 and then extended that out to
11 2018. So each -- I think it's on page 331 of the
12 application. You can see how we took each zip code and
13 broke it into each age cohort to come up with a growth rate
14 by zip code, by the primary and secondary service area.
15 MR. CARVALHO: When we discussed internally
16 looking at using Claritas in a similar way, one of the
17 shortcomings that we thought there was -- and, perhaps,
18 with your experience, you could clarify this -- was that
19 one of the things that we do is we get -- when we get our
20 analysis is we get a projection for the state population,
21 and then we distribute that population among our planning
22 areas so that it all tallies to the total. As you can
23 imagine, when someone does a projection that is based on a
24 local geographic phenomenon, looking at pulling permits and

1 birth rates and whatever in their area, they get a
2 projection for that local geographic area, but they do it
3 without regard to whether the numbers tally up to the
4 projection for the State, and so we make sure our
5 projections tie, so that the projections for each area
6 tally up to the State. Do you know -- project a total for
7 the State. Do you know whether that was done in this
8 instance, so that the Claritas projections for your area
9 would tie to the projections for the State as a whole?
10 MR. PIEKARZ: I cannot specifically say, but
11 the numbers that you've mentioned where population is
12 currently, is what we are seeing represented by Mr. Eesley.
13 As mentioned, the population in McHenry County and the
14 State of Illinois is tied to what Claritas is showing in
15 2010 as well, and the annual -- I guess to add on to that
16 more, the annual compounded growth rate for each -- both
17 our primary and our secondary service area, 1.8 percent was
18 the growth rate for -- annual growth rate for primary
19 service area. 1.2 percent aligns with what we've been
20 seeing as a reasonable growth rate, I would say, comparing
21 to even other areas outside of this geographic area.
22 MR. CARVALHO: Do you see what I was getting
23 at? We don't start with the number for 2010 and then find
24 out kind of what's going on in that location and project it

1 out 8 years, because we tie all of the numbers together so
2 that they add up, because otherwise, you can wind up with a
3 number that doesn't add up to what's expected to be the
4 total for the state.
5 MR. PIEKARZ: We've used Claritas for a number
6 of years and feel confident that is an accurate predictor
7 of population growth based on this type of category. This
8 has been a methodology for a number of projects.
9 MR. CARVALHO: That's helpful to know, because
10 we had a conversation internally about using Claritas, and
11 that conversation will now benefit from your experience.
12 MR. SEWELL: Mr. Chairman, this is a new Board
13 member question or comment. It seems like this is an
14 instance where an applicant has done something appropriate
15 and innovative, but it's not a part of the State's
16 approach. If the State has an approach where they start
17 with a use rate formula and they use population projections
18 for the state and then force those into Health Service
19 Areas, that may not be elegant, it may not be innovative,
20 but it's what we have, and until the State adopts an
21 approach like this, the question I guess would be can we
22 use it, can the State Agency Report, to draw the conclusion
23 that this meets a variance? Because if we do that, no
24 other applicant has access to that method, unless they are

1 fortunate enough to hire Deloitte Touche. It could be
2 correct, but is it something we can use as a policy for
3 saying yes, the rapid population growth variance has been
4 met? I'm making comments and asking questions at the same
5 time.
6 MR. CONSTANTINO: Do you want me to answer
7 that, Dave?
8 MR. CARVALHO: Sure.
9 MR. CONSTANTINO: Mr. Sewell, we looked at the
10 information. We compared it to what our rules were, what
11 they currently are, and they complied with our rules.
12 That's all we have to go on. And then we accepted it.
13 They complied with exactly what our rules require them to
14 do, our current rules require them to do. Now, we have our
15 own bed-need methodology, which we've discussed at length
16 here in this room today, and, as David said, we have more
17 current numbers now that would indicate that that bed need
18 methodology needs to be changed, not the methodology
19 itself, but the calculated need. But when I looked at this
20 application and reviewed the Deloitte study against the
21 rules as we have them now, it met those rules, in my
22 opinion.
23 MR. CARVALHO: If I could add to that, because
24 it's come up a couple times, and maybe I can wrap my

1 observation on all of these points. The conversation that
2 you're hearing now about this -- about utilization and
3 about the inventory reflects the fact that all of those are
4 procedures that we've set out in our rules. But following
5 those procedures doesn't lead to a no-brainer decision,
6 because there's weaknesses. I wouldn't call them
7 methodologically flawed, I'll agree with Mike on that, but
8 they're not methodologically perfect either. They are
9 processes that you've adopted in your rules that get data
10 that you then have to interpret and appreciate.
11 So, for example, the inventory numbers are the
12 way we've done it forever. You and I chatted at lunch a
13 little bit about this. It is the way it was done back when
14 you were involved in this process a long time ago. Is it
15 the only way to do it? No. Is it necessarily the best way
16 to do it? Who knows. It is the way we have done it, and
17 it gives information that you then have to decide how much
18 weight do you want to put on it. The information about the
19 variance, now you understand a little better about the
20 methodology. You then have to decide how much weight to
21 put on that, and the information about utilization, how
22 much weight to put on that, and then you come to a decision
23 for better or worse. None of these processes give you an
24 automatic, because it --

1 MR. SEWELL: I promise this will be the last
2 question on this. I get that, but here's the point: The
3 point is that it leads to be what appears to be a State
4 Agency Report conclusion that, therefore, there is an
5 accepted variance to computed bed need as advice to us, and
6 I guess what I'm questioning about that is all applicants
7 don't have access to this information, like they do the
8 other rules and guidance that we've established. That's
9 where the problem is for me.
10 MR. CARVALHO: I think I understand your
11 question. Let me address it and, Mike, you can see if I
12 get it right.
13 We have laid out in the rules a process that
14 you can use to seek that variance. So, everyone has that
15 information and know there is a process that is used. They
16 don't all have access to -- they only have access to the
17 data sources that they choose to access or to hire. You
18 can't get Claritas on the web. You have to contract with
19 them and get it. But it's -- but they all have access to
20 do that. They know what the rules are on how to do it.
21 But you're right, they do it privately, not publicly, like
22 we do it.
23 MR. PIEKARZ: Claritas data is available. I
24 would assume most providers in the hospitals in this area

1 are using Claritas as a planning tool. So -- and it is a
2 tool that's more provided to providers versus to consulting
3 firms, like myself. So we use it through Centegra, but,
4 again, like I say, I would think most hospitals, when
5 planning any type of project, are using Claritas in their
6 decision making.
7 MR. SEWELL: Okay. I'm violating -- one last
8 question. Why doesn't the State Agency Report just say
9 that the planning area need criteria is met? It doesn't
10 say that. It says "not met".
11 MR. CONSTANTINO: No, sir. If you look at all
12 of the criteria that we have, you have to look at the
13 existing facilities in that 30-minute or 45-minute travel
14 time, and they are not at the target occupancy. So you
15 have a situation where you have unnecessary duplication of
16 service with the existing facilities.
17 MR. SEWELL: But the calculated bed for needs
18 is met because of the variance.
19 MR. CONSTANTINO: Our calculated need is 83
20 med/surg beds. They provided us with information from
21 Deloitte & Touche that appeared to be reasonable to us,
22 indicating that that rapid population in that market area
23 was correct from our review and met our standards in our
24 rules.

1 MR. CARVALHO: Michael, if you -- everybody
2 has talked about this in terms of number of beds needed.
3 So, as you say, our inventory says 83. The adjustment for
4 the 2010 census discrepancy would suggest that as closer to
5 54. 64 of the beds come because of the migration factor.
6 Using that frame of reference, how many more beds need does
7 the variance add to the equation?
8 MR. CONSTANTINO: Dave, without going through
9 the process, I couldn't tell you right off the top of my
10 head.
11 MR. CARVALHO: Okay.
12 CHAIRMAN GALASSIE: I'm going to ask Board
13 members to give consideration to this issue. Are you
14 feeling comfortable that you can move forward with a vote,
15 hearing the dialogue that's taken place, or are you
16 feeling -- your options are, obviously, to defer or deny.
17 But I think we all get the point, and there is some
18 grayness to the basis of this. It's been ample dialogue.
19 If there are more questions, I don't want to close them
20 off. I know it's getting late in the day. Are we feeling
21 as though we're nearing a vote.
22 The motion that I would normally put out is a
23 motion to approve Project 10-090, to establish a 128-bed
24 acute care hospital in Huntley, Illinois at a cost of

1 approximately $234 million.

2 MR. GREIMAN: So moved.

3 CHAIRMAN GALASSIE: There's a motion by member

4 Greiman.

5 MR. BURDEN: I'll second.

6 CHAIRMAN GALASSIE: There's a motion and a

7 second on the floor. I'll entertain a roll call vote.

8 MR. ROATE: Motion made by Justice Greiman,

9 seconded by Dr. Burden, called for vote.

10 Dr. Burden?

11 DR. BURDEN: This has been a long day. I just

12 would like to comment before I try and explain. When I had

13 a tough case -- if there is another advisor or another

14 surgeon in the room he'd understand. If you have a tough

15 case, you want to do that early in the day, because as the

16 day goes on, focus disappears, and that's when surgeons

17 start to get upset, scream, holler and drive nurses nuts.

18 I don't think any of that occurred, but I'm now 78. When I

19 was working, I could handle it a little better, but I'm

20 overwhelmed with all of the data we've been listening to.

21 I'm impressed with our new Board members raising issues

22 that -- I'm trying to kind of play that I'm having trouble.

23 I have made my mind up, irrespective of what he said,

24 because I still feel concerned -- by the way I'm very

1 impressed with the time, the effort, the work, the
2 consultants, all this stuff that has been brought to the
3 table for us to cause us to do careful thought about what
4 you want to accomplish. I'm impressed with that. But I'm
5 not able to overlook the fact that we've got other
6 institutions in the planning area that are not -- their
7 med/surg levels are too low. I'm concerned about delusion
8 with a new, brand new facility. I think I would have to
9 vote no, although it's not -- it's somewhat reluctant, but
10 I still feel strongly that we should have a stronger base
11 in the area to allow for a brand new institution to appear.
12 Thank you.
13 MR. ROATE: Mr. Eaker?
14 MR. EAKER: I find it difficult to justify the
15 spending of $233 million with the hope that that would
16 somehow improve the cost of care for healthcare in this
17 area. I vote no.
18 MR. ROATE: Justice Greiman?
19 MR. GREIMAN: To be consistent, I vote aye.
20 MR. ROATE: Mr. Hayes?
21 MR. HAYES: I'd like to compliment the
22 applicant, as well as all of the people that have expressed
23 their support or opposition to this project, and it's been
24 a very interesting and very well, you know, process here,

1 and the application itself. Again, I'm looking at the
2 State Report and I'm looking at planning area need, as well
3 as maldistribution of services, and I -- that basically is
4 allowing me to come to the conclusion that at this time,
5 because of the -- some of the uncertainties with national
6 healthcare and also with the economy, and this project is,
7 at a minimum, going to be a couple of years later, won't be
8 completed until 2016, that I'm going to be -- I'm going to
9 vote no on this project.
10 MR. ROATE: Mr. Hilgenbrink?
11 MR. HILGENBRINK: I too would like to
12 compliment the applicant, and while they made some
13 compelling arguments, I too find that several of the
14 Board's criteria as they exist have not been met in terms
15 of need for the project and unnecessary duplication of
16 services. So, I reluctantly vote no.
17 MR. ROATE: Ms. Olson?
18 MS. OLSON: I'm also concerned for the other
19 providers within the service area, uncertainty about
20 healthcare in the future. I certainly commend you on your
21 presentation. I think you've given us some things to think
22 about, but at this time I need to vote no.
23 MR. ROATE: Mr. Penn?
24 MR. PENN: I agree. I think there is an

1 impact on the other providers of this area, and that causes
2 concern, and I don't believe that they have met the Board
3 criteria. So, at this time, I'm going to vote no.
4 MR. ROATE: Mr. Sewell?
5 MR. SEWELL: I vote no. I probably would have
6 voted yes with a deferral, just so we can -- so I can get
7 my mind straightened out about this variance. I think the
8 Staff -- the State Agency Report is a little confusing on
9 that point. But the no vote is based on the impact I think
10 it will have on occupancy with the existing facilities.
11 MR. ROATE: Chairman Galassie?
12 CHAIRMAN GALASSIE: The Chairman votes no
13 based on Board criteria.
14 MR. ROATE: That's eight votes in the
15 negative, one vote in the positive.
16 CHAIRMAN GALASSIE: Motion does not pass.
17 MR. URSO: You will receive an Intent to Deny.
18 You have another opportunity to come before the Board, as
19 well as provide additional information. Thank you.
20 CHAIRMAN GALASSIE: We are at 4:30 and,
21 obviously, we have been far overly aggressive on
22 anticipating on our agenda. This is a question for the
23 Board. Do you have another hour in you, and I will make an
24 apology to those of you who are in here. We will commit

1 another hour to see how far we can get, and then I think
2 we'll have to be rescheduling the remaining items on the
3 agenda for three to four weeks from now. Again, I
4 apologize. This has obviously gone much further than we
5 anticipated.
6 We're going to take a 10-minute stretch and
7 then pull it back together, please.
8 (Recess)
9 CHAIRMAN GALASSIE: We're going to revisit
10 the meeting. Thank you for being timely. We apologize
11 again. We are perhaps being equally unfair, and I regret
12 that. Obviously, those of you who have been here all day
13 didn't anticipate the length of the day.
14 We are going to go forward on the agenda with
15 Item 11-006. We then will be skipping down to 017, 018,
16 believing you are the furthest folks away. We will then
17 come back to the agenda, willing to be here until 5:30, and
18 we'll see how far we get, six o'clock. The sequence will
19 be starting out with 11-006 and then moving to 11-017,
20 11-018, the last two on page 4.
21 We have three individuals that have asked --
22 Wayne Smallwood, Jerome Finis, and Marie Carlson -- for
23 public hearing. Are you still interested in public
24 hearing, public comment?

1 (Pause)

2 CHAIRMAN GALASSIE: Hearing none, I'll say

3 no. Thank you.

4 We are now looking at Item 11-006,

5 Transitional Care Center of Arlington Heights. Staff

6 report, please.

7 MR. ROATE: Thank you, Mr. Chairman.

8 The applicant is Transitional Care Center of

9 Arlington Heights, LLC, and Transitional Care Management.

10 The applicants propose to establish a 120-bed, short-term,

11 skilled care facility in 71,600 gross square feet of space

12 in Arlington heights. The cost of the project is $22.2

13 million. The State Agency would like to note that a public

14 hearing was held. There were opposition comments. There

15 is a need in the planning area, and the application file

16 contains a support letter from the Illinois Department of

17 Healthcare and Family Services.

18 Thank you, Mr. Chair.

19 CHAIRMAN GALASSIE: Thank you.

20 Following the Staff report, gentlemen, you're

21 here for public?

22 (Oath given)

23 CHAIRMAN GALASSIE: Thank you.

24 MR. SMALLWOOD: Thank you for the opportunity

1 to address the Board in support of Transitional Care
2 Management. My name is Wayne Smallwood. I'm currently
3 Executive Director of the Affordable Assisted Living
4 Coalition. AALC is a trade association that represents
5 members who participate in Illinois' Medicaid-supported
6 model of affordable assisted living, known as the Supported
7 Living Program. Prior to becoming Executive Director of
8 the Coalition, I worked for 33 years for the Illinois
9 Department of Public Aid, now known as Healthcare and
10 Family Services and, as you know, HFS is the State agency
11 responsible for administering the State's Medical
12 Assistance Program and Medicaid coverage. I worked for the
13 Bureau of Long-term Care for the last 17 years in my State
14 career, retired in 2005 as Chief of the Bureau of Long-term
15 Care. The Bureau oversees long-term care programs
16 certified under Medicaid in Illinois.
17 During my tenure with Bureau of Long-term
18 Care, the State was faced with many challenges to keep
19 long-term care spending from escalating out of control.
20 Those challenges continue today. The State continues to
21 seek out programs that will offer improved service delivery
22 and quality of life with lower and more predictable cost.
23 In the 90's, one of the solutions for long-term care was
24 the development and implementation of the supportive living

1 program. Supportive living offers people who might
2 otherwise be placed in institutional settings the option of
3 a community dwelling with services that was not previously
4 available. The supportive living program continues to be
5 part of the evolution for long-term care, to place a
6 greater reliance on home care and assisted living and less
7 reliance on nursing facilities for those residents who can
8 thrive in a less-restrictive setting. Nursing facilities
9 are now and will continue to be relied upon for care of the
10 more acute, even subacute patients, who need to be
11 relocated from hospitals in a more expedient manner to a
12 more appropriate setting. Some nursing facilities are
13 reluctant to fulfill a new role in this evolution and want
14 to keep doing only what they have always done. This is
15 unfortunate.
16 I have known and respected Brian Cloch for
17 over 20 years. I have found him to be a person of
18 integrity and one who sees and wants to be a part of
19 important changes facing the healthcare industry. He was
20 always been willing to help solve issues involving
21 healthcare, and his input has been invaluable. Brian was
22 at the table with us at the State when we set out to
23 develop the supportive living program. His creative
24 approach to healthcare was evident then and it is today

1 with the Transitional Care Management model. He proposed
2 many regulations and operational guidelines that remain
3 with the supportive living program today. This is a time
4 for great change in healthcare not only in Illinois but
5 nationally as well. Creative systems and methods are being
6 looked at to bring healthcare to more people at less cost.
7 We need leaders who can help find and develop the new
8 approaches we must have to bring about the changes needed.
9 Brian Cloch is such a leader. He has met with State
10 officials at Healthcare and Family Services and has found
11 support to explore the Transitional Care model.
12 I urge this Board to show its wisdom and grant
13 approval so that Transitional Care can begin to bring its
14 advantages to the citizens and the State of Illinois.
15 Thank you.
16 CHAIRMAN GALASSIE: Thank you, Mr. Smallwood,
17 and we have your records -- your comments on the record as
18 well.
19 MR. FINIS: Good afternoon. I'm Jerome Finis,
20 the CEO of Pathways Senior Living. We own and operate 11
21 supportive living facilities comprising approximately 1,200
22 units in the Chicago metropolitan area.
23 As a business partner for the last 12 years
24 with Brian Cloch in Pathway Senior Living, I can speak to

1 his professionalism, creativity, integrity and total
2 commitment to quality of care. Also, as a supportive
3 living operator, we support the Transitional Care model
4 that they are proposing, proposed by them and their team,
5 as a creative and innovative model for the future. And
6 probably most importantly as a neighbor and a potential
7 targeted consumer for the transitional care facility in
8 Arlington Heights, living in the northwest suburbs, about
9 10 miles from his proposed site, I support the Transitional
10 Care model and the proposed facility as a great option and
11 a needed alternative for patients who are in need of
12 rehabilitation and who would prefer to receive those
13 services in another setting other than a traditional
14 nursing home. All of us in the healthcare industry are
15 having to adopt our services and models to different
16 customer bases and the customer of the future, and I
17 believe this project is going to be positioned to do that
18 and serve those people.
19 CHAIRMAN GALASSIE: Thank you very much.
20 MS. CARLSON: Good afternoon. My name is
21 Marie Carlson, and I am Senior Vice-President of Corporate
22 Strategic Development for Lutheran Life Communities, the
23 parent of the Lutheran Home a 119-year-old non-profit
24 organization that provides care to those in our community

1 regardless of ability to pay. We are located less than one
2 mile from the proposed project and will be severely
3 impacted by the construction and operations of this
4 project.
5 To keep this succinct, I have three points I
6 wish to share. First, the State Agency Report read that
7 this application is submitted based on a need for, quote,
8 short-term, skilled, rehab facility that focuses primarily
9 on high acuity patients with complex care needs, end quote.
10 This is not a new realm of skilled nursing services, as
11 stated in the SAR. This is a euphemism for Medicare
12 patients and Medicare reimbursement. Of the 17 long-term
13 care facilities in HSA 7-A, 16 already provided such care.
14 There is no shortage of short-term care beds in this HSA.
15 In fact, according to the State Report, of the facilities
16 located within 30 minutes of the proposed project, 83
17 percent of them are not at the 90 percent target occupancy.
18 In actuality, the average occupancy of these facilities is
19 78 percent. This translates to 1,261 patients, per the
20 Report, that could be accommodated at existing facilities
21 to reach the target occupancy of 90 percent, or 10 times
22 the number of the existing beds requested by the applicant
23 which are yet to be filled.
24 Based on the State's earlier explanation of

1 the calculation of bed need, the use of 2005 demographic
2 data, I would suggest that projections of demographic
3 growth have not materialized. Those of us who currently
4 serve patients within the planning area know this
5 firsthand.
6 Secondly, on page 5 of the SAR, it indicates
7 that there are 2,000 letters of support for this applicant,
8 but I would like to observe that in having reviewed these
9 letters, a majority of them are from writers who do not
10 live within the HSA, like downtown Chicago, Wheaton, and
11 Bolingbrook, to name a few, and none of them will be
12 impacted by this project in terms of service availability,
13 jobs or any other economic influence within our community.
14 Lastly, the State Report indicates on page 26
15 that a request for the proposed rezoning has been initiated
16 and is awaiting final approval from the Village of
17 Arlington Heights. Our attorney requested and received a
18 copy of the zoning application submitted to the Village,
19 under the Freedom of Information Act. Based on his review,
20 the zoning application contains information which is
21 directly contrary to the information submitted by the
22 applicant to you. As a part of the zoning application, a
23 parking assessment dated March 25th of 2011 was performed
24 and submitted to the Village of Arlington Heights, stating

1 the parking demand is based on the following number of
2 full-time equivalent employees: 40 FTE's from eight a.m.
3 to four p.m., 15 FTE's from four p.m. to midnight, and 15
4 employees from twelve a.m. to eight a.m., for a total of 70
5 FTE's. In contrast, page 153 of the CON states that they
6 will have 176 FTE's.
7 CHAIRMAN GALASSIE: Marie, are we close to
8 the end of your comments?
9 MS. CARLSON: Yes. The misinformation in the
10 zoning application is not your concern. However, these
11 discrepancies between the CON and the zoning applications
12 raise concerns about the credibility and integrity of the
13 representations submitted by the applicant to differing and
14 separate governmental organizations.
15 We respectfully request that you deny approval
16 of this Certificate of Need application, and thank you for
17 your time.
18 CHAIRMAN GALASSIE: Thank you very much.
19 Is there any other public comment on this
20 issue?
21 (Pause)
22 CHAIRMAN GALASSIE: Hearing none, we heard the
23 Staff report. Questions from the Board?
24 (Pause)

1 CHAIRMAN GALASSIE: We will now hear from the
2 applicants themselves.
3 (Pause)
4 (Oath given)
5 MR. CLOCH: I'm Brian Cloch, CEO of
6 Transitional Care Management. Jason Schreiber, my partner,
7 and Chris Dials, our consultant. Jason will speak a little
8 bit and I'll speak primarily. I apologize. I'm trying to
9 get this done quickly.
10 I'd like to thank the Staff for preparing such
11 a thorough report. We're delighted to see primarily
12 positive findings for our project. I would also like to
13 thank the person who spent the time scanning and posting
14 over 2,000 support letters. We appreciate your diligence.
15 Thank you also to the Board for being here today and
16 lending your expertise to discover the merits of this
17 project. I, too, volunteer my time to the State, for the
18 past 22 years, as the Chairman of the State Licensing Board
19 for nursing home administrators. I personally understand
20 and appreciate the time it takes to prep for these meetings
21 as well as attending them. I also want to thank you in
22 advance for giving this project due consideration and
23 recognizing upfront that this is a square peg in a round
24 whole scenario that needs to be understood not only by

1 standard merits but also by the special merits this type of
2 innovation presents to the current system.
3 First, let me tell you a little bit about
4 myself. I've worked in seniors housing for the past thirty
5 years and have developed, owned and operated subacute,
6 rehabilitation, skilled nursing, as well as assisted living
7 and independent living senior housing, all of which have
8 afforded me a well-rounded background.
9 Building a purposeful-built transitional care
10 center has been a dream of mine since my father-in-law was
11 rehabbed in a very nice, well-run nursing home following
12 hip replacement in the summer of 2008. He had the finest
13 of facility, services, and medical care, and he begged me,
14 "Get me out of here." It was the best of the best. He
15 hated it because it was the institutional feel, primary
16 focus of an older, long-term care population, poor quality
17 of food with the lack of amenities, the fact that he
18 couldn't get a good night's rest, the fact that the shower
19 was down the hallway. I listened to him. I knew that
20 there had to be a better way, so I researched it and found
21 out there is.
22 Transitional Care is a successful model that
23 is happening all over the country. Illinois is just a
24 little slower to react. It addresses the long-standing,

1 untapped need to reform short-term rehab care. Like the
2 introduction to assisted living 20 years ago, the
3 introduction of supported living 10 years ago, stand-alone
4 transitional care is the next natural evolution for this
5 industry. So let me tell you a little bit about the
6 project.
7 Transitional Care Center of Arlington Heights
8 is not another transitional nursing home. Our goal is to
9 not build a nursing home. Rather our objective is to
10 reinvent post-acute experience. Transitional Care of
11 Arlington Heights intends to create a post-acute care
12 delivery model. I'm sure that you or a friend or relative
13 that has needed this level of care at some point in time.
14 We all know that the current options are simply
15 unacceptable. Bridging the gap between illness and
16 recovery requires state-of-the art technology, efficient
17 and effective clinical expertise, caring and supportive
18 overall environment that promotes healthy healing.
19 The Arlington Heights Recovery Center will
20 provide a health balance of the finest of facilities,
21 treatment protocols, and highly skilled care, along with
22 the comfort and convenience of a non-institutional
23 alternative setting. We will have primarily private room,
24 private baths and showers -- showers, not baths -- optional

1 patios, home-like furnishings, comfortable accommodations
2 for guests, restaurant-style dining options, thoughtful
3 conveniences to minimize disruption and offer privacy,
4 signature spa-like amenities, a dedicated focus on
5 post-acute care.
6 Transitional Care will address specific under
7 served need and offers a welcome innovative alternative
8 while helping to control costs and minimizing the higher
9 costs of alternative settings when they are not medically
10 necessary. When you see all Transitional Care of Arlington
11 Heights has to offer, you can understand why those who
12 represent the status quo might feel threatened by this bar
13 raising. I encourage the Board to not let the perceived
14 threat of competition stand in the way of innovation.
15 There are several reasons why this project
16 should be approved. First let's talk about need. As the
17 Report states, there is an 891 bed need, a dramatic number,
18 as stated by the State of Illinois May 11th inventory,
19 updated for this service area. The need has been clearly
20 defined and documented. It is true some of these
21 traditional nursing homes in the area are below the
22 targeted occupancy. Let's ask why.
23 First of all, many of these beds are not full
24 because they are not in service. Report occupancy

1 calculations are based on licensed beds, not actual
2 operating beds. Many of those licensed beds have been
3 taken out of service, because consumers like you and I
4 don't want dual or triple occupancy. They cannot be
5 occupied because they don't exist. Of note is the fact
6 that many of the remaining beds are located in continuing
7 care retirement communities that do not accept admissions
8 from the general market.
9 Next let's talk about distribution. 64
10 percent of the facilities within a 30-minute drive time had
11 a quality ranking of three or lower. It's a CMS ranking
12 that the feds do to rank nursing homes. Frankly, people
13 don't want to go there. Only 10 percent of providers in a
14 30-minute drive time have a five-star quality rating.
15 There are only two top quality providers in the Arlington
16 Heights market, and they are four-star rated, not five, and
17 both are faith-based. We have multiple reports about not
18 being able to get into the area of quality providers of
19 post-acute stage due to lack of bed availability or payor
20 mix.
21 On the matter of duplication of services, not
22 one provider listed in the report had offered stand-alone,
23 purpose-built, specialized short-term care. Actually,
24 there is no duplication of services, because no one is

1 doing this in this manner. Rather, these existing
2 traditional nursing homes provide an institutional model
3 for custodial care of geriatric residents that is
4 supplemented with a small rehab unit designed to capture
5 Medicare reimbursement when their internal residents return
6 from the hospital.
7 The existing inventory is primarily a
8 combination of old or neglected buildings, semi-private
9 rooms, shared bathrooms and showers, small therapy space,
10 and outdated equipment. While other fine medical
11 facilities -- while there are other fine medical facilities
12 in the area that have upgraded, post-acute care in the area
13 is, by comparison, antiquated. The hospital itself does
14 not offer these services. No duplication there. The only
15 alternative is home care, and as a home care company owner,
16 I can promise you that in many of these cases,
17 hobbled-together home care solution is not the best option.
18 The overwhelming majority of these nursing homes primarily
19 care for an older population. In fact, 2009, the Lutheran
20 Home for the Aged served only a total of three patients
21 under the age of 65, Transitional Care's primary targeted
22 market.
23 There is no duplication of services.
24 Transitional Care of Arlington Heights will reach people

1 with needs that are not being met by the existing nursing
2 homes, people like my father-in-law, people like David Zin
3 (phonetic), who recently underwent cervical spine surgery,
4 who wrote in support of the project, because he found that
5 "as a divorced, single father living in Arlington Heights,
6 my only option for care coming out of the hospital was a
7 nursing facility that served elderly people". People like
8 the thousand people who wrote support letters for the
9 project, who don't want to share a room or walk down the
10 hallway to use a bathroom or shower, if they should, God
11 forbid, fall and break a hip or need rehab. People like
12 high acuity Medicaid residents, who are not currently
13 admitted by existing area nursing homes, who have to remain
14 in the hospitals, the highest cost setting, thereby
15 removing critical hospital beds for accepting new patients.
16 And people like the area healthcare officials, over a
17 hundred doctors, nurses, therapists, geriatric care
18 managers, hospital CEO's, insurance providers who wrote in
19 support of our project. They know there ought to be a
20 better way. In fact, Transitional Care Center of Arlington
21 Heights has secured documented referrals from a large
22 physician group that serves the planning area. These
23 referrals are in excess to the number of referrals needed
24 to support the project.

1 When all is taken into consideration, it is
2 clear that Transitional Care Center is targeting an under
3 served market. As such, existing facilities that do not
4 meet the needs of this market will experience little
5 impact.
6 CHAIRMAN GALASSIE: Jason, I just wanted to
7 ask, are you going to touch on the public comment that was
8 just made about the zoning discrepancy?
9 MR. SCHREIBER: I was initially going to
10 respond to some of the comments in the State Agency Report
11 that address some of the financial ratios. As Brian
12 mentioned, this is a project that the ratios didn't
13 necessary contemplate this type of innovation, this type of
14 different service level, this different type of physical
15 plan, and so we do cross some of the thresholds. A couple
16 of the more important ones I wanted to touch on, the first
17 one being debt to capital.
18 Our overall capital structure, as noted in the
19 report, is 82 percent versus the recommendation of 80.
20 We're pretty close, but we are just over it. The reason
21 for that is our intended source of financing is HUD. We've
22 received an indication, which was included in the
23 application, from C W Capital, who is one of the largest
24 HUD lenders in the country, who has done a number of

1 Transitional Care projects in western states, who has
2 familiarity with this project. HUD, as I indicated, will
3 finance up to 85 percent of the capital structure. In this
4 case, we've modeled 82 percent, which we think is a viable,
5 achievable level, both in terms of debt and for the
6 sustainability of the project and our ability to service
7 that debt load on an ongoing basis.
8 The other ratio that was noted was the cushion
9 ratio, which in essence is a measure of cash liquidity to
10 support the debt on an ongoing basis. As a start-up, as
11 you might imagine, we are not sitting on significant
12 amounts of cash, and so that debt ratio will be low. Over
13 time, as we stabilize and operate at our projected levels
14 through years three, four and five, we will build that
15 ratio up and be able to achieve the desire thresholds I
16 indicated in the Agency Report.
17 So, in terms of key matrix that the debt
18 providers look at, we feel this project is imminently
19 financeable. It generates a stabilization debt service
20 coverage that is better than three times, as well as will
21 generate a loan to value that's approximately 65 percent
22 loan to value, which those of you who are familiar with the
23 lending community, that's a very comfortable level for many
24 debt providers. So, we're very optimistic about the

1 financial viability as it relates to the ratios, as well as
2 the traditional debt underwriting matrix.
3 MR. CLOCH: As far as the zoning, the parking
4 issues, having been involved in 18 successful development
5 projects with zoning issues that go on with those, two of
6 which that is under construction now in Vernon Hills, there
7 was a discrepancy between one consultant to another
8 consultant. So the part of our application that went in on
9 the CON, and then with the parking consultant and everybody
10 else, there was a disconnect there. It was brought to our
11 attention, honestly, with the letter as well. We weren't
12 aware of the discrepancy either, but we are addressing that
13 with the Zoning Board. So, it's just an honest mistake.
14 CHAIRMAN GALASSIE: Thank you.
15 MR. SCHREIBER: The key point is that the
16 numbers in the application in terms of our overall staffing
17 level is the staffing level that we intend to operate this
18 facility at, and we really think it's necessary to develop
19 the quality of care and the level of service that these
20 patients will require.
21 MR. CLOCH: I just want to conclude. And
22 finally, most importantly in my opinion, let's talk about
23 quality. A vote for Transitional Care is a vote for
24 quality. Transitional Care's specialized focus will

1 enhance outcomes and patient experiences. Transitional
2 Care's nurse to resident ratio is much higher than nursing
3 home industry. Our Transitional Care will coordinate with
4 area physicians and hospitals to offer a critical pathway
5 to address high rehabilitation and complex care needs.
6 And, lastly, multiple studies show that
7 healing design, like what Transitional Care proposes, can
8 improve a patient's outlook on care. Increased patient
9 satisfaction ultimately help the support of clients
10 returning to recovery. Furthermore, I defer to others who
11 wrote in support of my personal credibility and commitment
12 to quality to speak for me. Theresa Eagleson, the
13 Administrator for Illinois Healthcare and Family Services,
14 Division of Medical Programs, wrote that "the Department
15 maintains a very positive, professional relationship with
16 Mr. Cloch, values his involvement in the program and
17 considers Mr. Cloch to be a resource for innovation and
18 progressive leadership."
19 In summary, healthcare reform will continue to
20 change our norm. Shorter lengths of stays will increase --
21 shorter lengths of stays and increase in outpatient
22 procedures will continue to discharging people sicker and
23 quicker, thereby driving an increased need for high
24 quality, short-term, high acuity, post-acute care. There

1 is a stated documented, published need of 891 beds in the
2 planning area that Transitional Care Center of Arlington
3 Heights only begins to address. Furthermore, there is a
4 desire on both the part of the consumers and healthcare
5 community to bring a new choice to the marketplace. This
6 is not only -- not really a conversation about duplication
7 or maldistribution. It's truly a conversation about status
8 quo and innovation. At a time when money is scarce, costs
9 are soaring and our nation is aging, we need to explore
10 cost-effective, customer centric and innovative
11 alternatives to healthcare's current status quo.
12 Transitional Care of Arlington Heights offers choice, it
13 offers quality, it offers cost savings. Transitional Care
14 is the model of the future. Hospitals know it, doctors
15 know it, insurers know it, and patients want it.
16 Please vote in favor of bringing innovation to
17 Arlington Heights. Thank you.
18 CHAIRMAN GALASSIE: Thank you. Questions by
19 Board members?
20 MR. BURDEN: The prior nursing and long-term
21 care facility contractors and owners and builders have
22 commented regarding the Medicare star rating. When it
23 appears to be favorable to the applicant, they think it's
24 worthwhile. When it doesn't, they think it's nonsense.

1 What's your opinion of the Medicare star rating when
2 applied to the facilities within 30 minutes travel time of
3 your facility?
4 MR. CLOCH: I would say if you look at the
5 data, facilities that have the higher star ratings have the
6 higher occupancy rates.
7 MR. BURDEN: Excuse me for interrupting you.
8 How do you account for three of them -- one, two, three --
9 one 67 percent, one 48 percent. 83 percent is not bad.
10 That's what caught my attention.
11 MR. CLOCH: Those facilities were built with
12 semi-private rooms, so two-person occupancy. So in order
13 to fill their beds, they dropped it to single-person
14 occupancy. So when you look at their occupancy, it's
15 licensed beds versus occupied beds. It's sort of a
16 misnomer, because if you -- if our facility is licensed 120
17 beds we're going to have, you know -- there's only going to
18 be six semi-private rooms that are shared. But when that
19 facility was built, it was built with all semi-private
20 rooms, but currently the consumers are choosing to be in
21 private rooms. So it looks like the occupancy is low but
22 in reality --
23 MR. BURDEN: So it's got 90 percent private
24 rooms?

1 MR. CLOCH: Our building only out of -- the
2 design -- there's going to be six semi-private rooms and
3 the rest are going to be private rooms.
4 MR. BURDEN: Indoor showers, indoor plumbing?
5 MR. CLOCH: Yes, showers in all of the rooms,
6 patios in most of the rooms, so they can get to the outside
7 without going through the building. So it's going to look
8 and feel very residential, look and feel hotel-ish but act
9 like a medical facility. Pumped-in oxygen --
10 MR. BURDEN: You speak rather rapidly. You
11 have to recognize I'm a little older than that you, so if
12 you slow down --
13 MR. CLOCH: I apologize.
14 MR. BURDEN: I'm asking because I suspect that
15 you're not really required to -- your charity care, I don't
16 see any evidence that you are -- I've got 100 percent are
17 covered by private pay, Medicaid, Medicare or HMO. Is that
18 correct?
19 MR. CLOCH: Correct. In regards to charity
20 care, I've had two meetings now with the Illinois
21 Department of Healthcare and Family Services to create a
22 reimbursement system for Medicaid residents at a hundred
23 percent Medicaid, no Medicare coverage, who are currently
24 in hospitals an excessive period of time because the

1 reimbursement system doesn't allow them to leave. There's
2 no provider willing to accept a high acuity Medicaid
3 patient. So the State recognizes there is a gap between
4 what a typical nursing home can get paid and what a
5 high-acuity resident needs.
6 MR. BURDEN: Our State Agency had a little
7 problem figuring out your financial guide. I'm trying to
8 find it. Where was it.
9 You're a start-up company, so "the applicant
10 does not meet the requirements of this criteria". I'm
11 asking, because I'm not sure I understand. The net margin
12 percentage, does that refer to the margin of profit or
13 return on investment, or what's this net margin mean.
14 MR. CLOCH: I'm not sure of the number you're
15 looking on.
16 MR. BURDEN: Page 31 of the --
17 CHAIRMAN GALASSIE: Staff, want to address
18 that question?
19 MR. CONSTANTINO: Yes. It's the net margin
20 percentage referenced here, 6.19 percent.
21 MR. BURDEN: What is it?
22 MR. CONSTANTINO: It's their profit.
23 MR. BURDEN: That's what I wanted to hear.
24 Return on their so-called profit, at least based on the

1 calculations that have been made regarding occupancy, cost,
2 et cetera. Okay. Since it's listed as -- it doesn't
3 appear to meet the criteria of a financial viability
4 criteria. You describe -- you're involved in other
5 facilities, I would assume. Are you challenging your
6 financial viability.
7 MR. SCHREIBER: I think our number of 6.19
8 percent, I believe, exceeds the threshold of 3.5 percent.
9 MR. BURDEN: Yeah, I know it exceeds it. I'm
10 asking just what it is, that's all.
11 MR. CONSTANTINO: Yeah.
12 MS. OLSON: I have another question or
13 clarification on a comment you made. Did I understand you
14 to say that you your target market would be age 65 and
15 younger or 65 --
16 MR. CLOCH: Our target market is anybody
17 that's post-acute, anybody that is in the hospital, coming
18 out of the hospital, who is interested in living in a
19 senior community. I believe and what our statistics have
20 seen, there are a lot of people in the younger ages using
21 home care that are not getting positive results. I could
22 tell you many stories. So, we're building the building
23 with the concept of the Baby Boomer generation, who is not
24 interested in going into a -- for short-term, 14 to 17 day

1 length of state, into a Lutheran Home for the Aged, as an
2 example, but an age -- a senior --
3 MS. OLSON: So do you have a projection what
4 you think your average length of stay will be? Because it
5 sounds like you're going to turn your beds over.
6 MR. CLOCH: 14 to 17 days is what we're
7 anticipating.
8 MS. OLSON: So, really, in my mind, you're not
9 duplicating an existing service at all. I mean, I love the
10 innovation here. If I break my hip, can you have it done
11 in time for--
12 MR. CLOCH: Yes. We've got a lot of public
13 comments, actually, but that's exactly the market we're
14 going toward, 14 to 17 day stay, and then pretty much
15 people will leave with home care. We're just trying to get
16 them in out safely.
17 MR. BAKER: So your target will be Medicare
18 patients?
19 MR. CLOCH: I would say commercial insurance
20 patients will probably be the majority of our population.
21 We've had discussions with Blue Cross/Blue Shield and Aetna
22 and everybody, because they want to shorten the length of
23 the hospital stay, but a lot of people are refusing to
24 leave the hospital when they're told that the only option

1 is a senior living building or a section of a senior living
2 building. I hope that answers your question. We're
3 targeting, really, anybody that is in the hospital that
4 could do better at a less expensive environment than a
5 hospital.
6 MR. EAKER: What is the 14 to 17 day time span
7 representative of if it's not the reimbursement rate for
8 Medicare?
9 MR. CLOCH: The reimbursement for Medicare
10 goes 100 days.
11 MR. EAKER: Well, technically it could be, but
12 20 days is all practicality.
13 MR. CLOCH: 20 days is the day that there's no
14 copayment, and that's typically -- but that has nothing to
15 do with the our length of stay. Our length of stay is
16 generated by my experience, having done this in other
17 buildings. That's generally the length of stay. It's not
18 tied to anything financial.
19 MR. BURDEN: I'm sorry to keep coming back,
20 but perhaps you can help me straighten out my senility
21 here. There are 58 total, on Table 1, facilities, of which
22 48 are not met occupancy. We've had previous applicants
23 here where the occupancy of hospitals, et cetera, is a key
24 factor in our evaluating whether or not another institution

1 is needed in the planning area. Why am I looking at such a
2 high occupancy number? I think you tried to explain it by
3 the way that they run their nursing homes. I don't know,
4 but you tell me. It's inordinately high number, which
5 would ordinarily make me say what's going on here.
6 MR. CLOCH: I would tell you it's indicative
7 of the quality of the facilities. Once again, if you look
8 at the higher rated facilities, by using the CMS rating --
9 which you can argue with or against -- but using -- that's
10 the only measure that exists right now. If you use that
11 measurement tool, the higher rated facilities have a higher
12 occupancy, except for those that have turned their beds
13 into -- semi-privates to privates. So, it's misleading,
14 the information, and the other facilities are antiquated in
15 technology. So I think that consumers are choosing
16 alternatives versus going to nursing homes.
17 MR. DIALS: Chris Dials. I would also point
18 out that the general long-term care category is a very big
19 bucket, of which there are many different businesses done
20 within those beds, and if you were to go to look for a
21 facility, after you broke your hip, in Arlington heights,
22 you would have a very difficult time finding a bed for a
23 short-term rehab stay. The rehab units within the
24 facilities in that market are full, by and large, for that

1 service.

2 CHAIRMAN GALASSIE: Any other questions on

3 part of Board members?

4 MR. SEWELL: Yeah. As of the State Agency

5 Report here, that loan is not secure. Is that secure now?

6 MR. CLOCH: Nothing is secure until you get a

7 CON.

8 MR. SEWELL: We're in the way?

9 MR. CLOCH: Yeah, and the zoning.

10 MR. SEWELL: And then you have these ratios

11 that the Staff talks about, the cushion ratio and the debt

12 to total capitalization. I mean, does this tell a story

13 that the overall project might be under-capitalized.

14 MR. SCHREIBER: I don't think that does at

15 all. I mean HUD -- the HUD criteria is up to 85 percent.

16 I think this year HUD will do in excess of $2 billion of

17 financings for skilled nursing facilities all over the

18 country, and they have, over their 20-year, 30-year history

19 of financing skilled nursing care facilities virtually zero

20 losses relative to the overall size of their portfolio.

21 So, I think that's a very reasonable level of debt and

22 leverage and an appropriate capital structure for this type

23 of asset.

24 CHAIRMAN GALASSIE: Do we concur with that?

1 We don't have an issue there?

2 MR. CONSTANTINO: That's correct, Dale.

3 MR. CLOCH: There's lenders and equity

4 investors chasing us. This model is incredibly innovative.

5 It's happening all over the country, except for Illinois.

6 This will be the first truly free-standing transitional

7 care facility in Illinois. They're all over Texas, Ohio,

8 and California, and they're incredibly successful.

9 MR. SEWELL: What is your response to the

10 State Agency Report stating that some of your project costs

11 are excessive? That's one of the findings.

12 MR. CLOCH: It goes back to the same

13 innovative model. We're building 92 percent private rooms.

14 We're building a suite for people to stay overnight if

15 you're going to stay with your husband, don't want to stay

16 in the room. So, we're just over the threshold sort of

17 things. Square peg in a round hole. It's innovation and,

18 as I said, I mean, that's why I'm hoping and praying for

19 you guys to recognize it's innovation, and the message to

20 be sent to the industry is we want innovation, we don't

21 want more of the same.

22 CHAIRMAN GALASSIE: Mr. Hilgenbrink?

23 MR. HILGENBRINK: Just answered my question.

24 CHAIRMAN GALASSIE: Any other questions on

1 part of the Board?

2 MR. PENN: Just looking at this star rating,

3 you said the facilities with the higher number has the

4 greatest occupancy, and I don't see that to be true. I see

5 some here with a star rating of 1 at 84 percent, star

6 rating of 2, 88.5 percent, several that -- 1's and 2's that

7 are over the 75 percent.

8 MR. CLOCH: I can't explain that. I will tell

9 you in the primary market that we're in, there's only two

10 4-star rated facilities and their occupancy rate is

11 relatively high. The Rosewood facility, which is in

12 Inverness, has got a high rating. I think it's the only 5

13 rated facility, and their occupancy looks low because

14 they're all converted to private rooms. So they're

15 licensed to functional occupancy is different. But as far

16 as what I can address on the 1 or 2 stars, I don't pay much

17 attention to those.

18 MR. PENN: This goes back to my concern about

19 the maldistribution of services. You're stating that you

20 are going to provide a better quality?

21 MR. CLOCH: Well, I would argue if the 1 or 2

22 stars had high occupancy, then consumers aren't really

23 getting choices of quality. They're having to go to lower

24 quality facilities if they have high occupancy.

1 CHAIRMAN GALASSIE: But I think we're in a
2 subjective area.
3 MR. PENN: Yeah, I think we are.
4 CHAIRMAN GALASSIE: With all due respect.
5 MR. CLOCH: I agree.
6 CHAIRMAN GALASSIE: I'm going to suggest to
7 call for a vote. The motion would be to approve Project
8 11-006 for the establishment of a 120-bed long-term care
9 facility in Arlington Heights, at a cost of $22+ million.
10 MR. HILGENBRINK: So moved.
11 MR. BURDEN: Second.
12 CHAIRMAN GALASSIE: Motion by Mr.
13 Hilgenbrink, second by Dr. Burden. Roll call, George.
14 MR. ROATE: Dr. Burden?
15 MR. BURDEN: If I can talk as fast as that
16 guy -- yes.
17 MR. ROATE: Mr. Eaker?
18 MR. EAKER: Due to several State criteria not
19 being met and what basically I believe you're going after
20 is the cream off the top of the crop, I vote no.
21 MR. ROATE: Justice Greiman?
22 MR. GREIMAN: I must recuse myself from this
23 matter.
24 MR. ROATE: Mr. Hayes?

1 MR. HAYES: Yes.

2 MR. ROATE: Mr. Hilgenbrink?

3 MR. HILGENBRINK: Yes.

4 MR. ROATE: Ms. Olson?

5 MS. OLSON: I am voting yes, and I want to say

6 I love the innovation. Thank you.

7 MR. ROATE: Mr. Penn?

8 MR. PENN: I'm going to vote yes. I struggled

9 with this, but with the innovation and the presentation, I

10 will vote yes.

11 MR. ROATE: Mr. Sewell?

12 MR. SEWELL: I vote no. There are some

13 financial and reasonableness of project cost criteria that

14 are not met, according to the State Agency Report.

15 MR. ROATE: Chairman Galassie?

16 CHAIRMAN GALASSIE: Yes.

17 MR. ROATE: That is six votes to the positive,

18 two votes to the negative, and one vote of recusal.

19 CHAIRMAN GALASSIE: Motion passes.

20 Congratulations. Good luck.

21 Moving forward to Item 11-017, Memorial

22 Hospital East, there are some people that have signed up

23 for public testimony, and if you feel strongly for the need

24 to do so -- if it's something that's already in the record,

1 I assure you the Board probably does not need to hear it.
2 But we will respect your right, as you have sat here all
3 day as we have. So we're going to call a name and you can
4 tell us yes, if you're going to speak, or no.
5 (Pause)
6 (Oath given)
7 MS. BADGLEY: I am Peg Badgley. I serve as an
8 Honorary Board Member. I've been involved in the hospital
9 for 53 years, serving in leadership for 30 years, and for
10 the sake of your time and your energy and your patience, I
11 forego all of the comments I was going to make. But I
12 strongly support the application, and I hope you all will,
13 too. Thank you.
14 CHAIRMAN GALASSIE: Thank you, Ms. Badgley,
15 and we appreciate that very much.
16 MR. ECKERT: My name is Mark Eckert. I have
17 the privilege of serving as Mayor of the City of
18 Belleville, Illinois. We are home to Memorial Hospital.
19 Belleville, Illinois is the largest city south of
20 Springfield. We're the county seat of St. Clair County.
21 The City Council and I support Memorial's
22 request here today for their satellite facility. We
23 appreciate the community support and the continuous growth
24 and ministry to citizens in Belleville, almost 45,000, and

1 to people throughout St. Clair County a county of 280,000
2 population. Belleville Memorial is located in West
3 Belleville. We're a unique city. We're almost 200 years
4 old. We're ten miles long, and they have the unique
5 challenge of abutting some parts of our county,
6 particularly East St. Louis, Illinois, that has changed
7 drastically over the years with poverty and crime and many
8 challenges. Belleville Memorial serves very graciously and
9 outstandingly to the poor and to people who are broken.
10 They have been a true public partner.
11 One of the reasons I'm so strong and our City
12 Council is strong for this project, they continue to be
13 committed to their base facility, their flagship in
14 Belleville now. Evidence right now of a $25 million
15 project, orthopedic building, the renovation right now of
16 their convalescent center, the constant renovation that is
17 very noticeable when you go to the facility, both in
18 technology and the appearance of the buildings. Over the
19 years, they have done a tremendous job of reinvesting.
20 Because of their support and their growth in Belleville, we
21 do not have a problem with their satellite request. We see
22 them as an ongoing community partner that only strengthens
23 the entire region, and it's important to our city that we
24 continue to grow.

1 CHAIRMAN GALASSIE: Thank you, Mr. Mayor.
2 MR. VERNIER: Good afternoon. My name is Jim
3 Vernier. I'm the Mayor of Shiloh, Illinois. I'm here to
4 ask for your full support for the Certificate of Need for
5 Memorial Hospital's satellite facility in Shiloh. This
6 will provide needed convenient access to hospital services
7 in our community and curb the out-migration of Illinois
8 residents who go to Missouri for care. Right now, as you
9 know from Memorial's application, residents in my community
10 are leaving Illinois to receive care in Missouri. Keeping
11 Illinois patients here will ensure that their healthcare
12 dollars are spent in Illinois, helping to boost the area's
13 economy. I can assure you it's millions of dollars a year
14 that are going across the river to Missouri.
15 Shiloh is located on interstate 64, which is
16 the pipeline east and west straight to St. Louis. We're
17 about 25 miles from the Missouri border and the university
18 hospitals over there. Despite the fact that we have a
19 strong medical community, the lack of accessible private
20 beds, which has become an expectation for many patients,
21 has resulted in significant out-migration of my
22 constituents, as well as other residents in our neighboring
23 community to the north and the east. I -- this project is
24 not only good for Shiloh but good for the entire region.

1 Our neighbor to the north is 25,000
2 population. There is no hospital there. Our population is
3 twelve five. We have no hospital. Our immediate neighbor
4 to the east is Scott Air Force Base. It's a United States
5 patient transport command home base. There is no hospital
6 there. Fortunately Belleville does have Memorial, and
7 we're thankful that they are proposing a new one in Shiloh,
8 and I ask for your full support.
9 Thank you.
10 CHAIRMAN GALASSIE: Thank you. Next, please.
11 MR. WESTON: Ed Weston. I'm Senior Pastor of
12 Union United Methodist Church in downtown Belleville. Our
13 church was one of the founders many years ago, prior to my
14 coming there, of course, but, again, I will reserve my
15 comments in the sake of time but strongly, strongly support
16 this CON.
17 CHAIRMAN GALASSIE: Thank you, Pastor. We
18 appreciate that.
19 MR. MARTINS: My name is Les Martins, and I
20 serve on the Board of Directors of Memorial Hospital, in
21 addition to Memorial Group Incorporated. I've been
22 involved with the hospital since 1987 as a board member, so
23 it's slightly over 24 years. Been very instrumental in the
24 planning of this process and the purchase of the property,

1 et cetera, and I wholeheartedly support the movement going
2 ahead and ask for your approval also and, again, in essence
3 of time, I defer any questions.
4 CHAIRMAN GALASSIE: Thank you, Les. We
5 appreciate that.
6 MR. MORTON: Steve Morton, orthopedic surgeon
7 at Belleville Memorial Hospital. Just in support of
8 increasing the modernization, private beds and maintaining
9 the patients on this side of the river.
10 CHAIRMAN GALASSIE: Thank you, Steve.
11 Appreciate your comments.
12 MR. MERRITT: My name is Mel Merritt. I'm
13 obstetrician/gynecologist at Memorial in Belleville. I
14 wanted to comment and lend my support for the project. I
15 think that the upgrade to private rooms both in Belleville
16 and in the new facility in Shiloh will really help
17 patients, and I am a newcomer to the area. I've only been
18 in the area for about four months, and I'm already full, so
19 there is a great need for more obstetrics facilities, and
20 the patients, I think, warrant the upgrade in facility and
21 technology.
22 CHAIRMAN GALASSIE: Thank you, Doctor.
23 MS. RIVERA: Hi. I'm Summer Rivera. I'm from
24 the Strategic Planning Department with Hospital Sisters

1 Health System. I am here to actually ask for opposition
2 for this project for a few reasons. One, all facilities
3 within this planning area are under utilized. Today
4 Memorial Hospital in Belleville is not operating at the
5 target occupancy rate.
6 Two, they have been unable to provide
7 assurance that by the second year the project is complete
8 that OB will achieve this target occupancy.
9 Three, negative impact on other area
10 facilities which are already operating under standards is
11 expected.
12 Four, the beds being requested do not meet the
13 State minimum requirements. 72 med/surgical beds, the
14 minimum as you know is 100. 16 OB beds, the minimum is 20.
15 Five, they have been unable to meet the
16 current ratio and net margins, making the financial
17 viability of this project unfavorable.
18 Six, the project cost exceeds the State
19 standards for new construction and contingency cost
20 standards.
21 And, seventh, will result in unnecessary
22 duplication of cardiac cath services in this planning area.
23 For these reasons, I am asking that you vote
24 in opposition to this project.

1 CHAIRMAN GALASSIE: Thank you very much, Ms
2 Rivera.
3 Any other public comment.
4 (Pause)
5 CHAIRMAN GALASSIE: Hearing none, we thank you
6 very much.
7 I would ask that the representatives from
8 Memorial Hospital please come up to the table, and while
9 you are doing, so I will ask for our Staff report on this
10 agenda Item.
11 MR. CONSTANTINO: Thank you, Mr. Chairman.
12 The applicants, Memorial Group, Inc. and Metro-East
13 Services, Inc., are proposing to establish a 94-bed acute
14 care hospital, 72 med/surg beds, 16 OB beds, and 6 ICU beds
15 in approximately 206,000 gross square feet at a cost of
16 approximately $119 million. The proposed project is before
17 the State Board because it proposes a healthcare facility
18 as defined by the Act. As part of this project, the
19 applicants will discontinue 78 med/surg beds, 21 OB beds
20 and 12 ICU beds at Memorial Hospital in Belleville. There
21 was no public hearing, and 27 letters of support were
22 received by the State Agency. One letter of opposition was
23 also received.
24 The State Agency notes the following: There is

1 a calculated excess of 527 med/surg ped beds, 28 ICU beds,
2 128 OB beds in this planning area. There are 9 existing
3 hospitals in this planning area, FO-1 Of these 9
4 hospitals, none of the hospitals meet target occupancy for
5 med/surg beds, 1 of 8 hospitals meets target occupancy for
6 OB beds, and 3 of 9 meet target occupancy for ICU beds.
7 The applicants did not meet the 100-bed minimum requirement
8 or the 20-bed OB requirement for the establishment of a
9 hospital in an MSA. The applicants were not in compliance
10 with the current ratio or the net margin ratio for 2008.
11 The project exceeds the construction and contingency
12 standard by approximately $867,000 and is in excess of the
13 contingency standard by approximately $2,100.
14 I will little note for the State Board, we did
15 receive responses to the cardiac cath services that are
16 being proposed by this project. One response was from
17 Anderson Hospital, who could not make a determination of
18 the impact the proposed cardiac cath service would have on
19 the service, and a second response from St. Elizabeth
20 Hospital, Belleville, who stated the proposed cardiac
21 service would have a negative impact on their cardiac cath
22 service.
23 Thank you, Mr. Chairman.
24 CHAIRMAN GALASSIE: Thank you, Mike.

1 (Oath given)

2 MR. TURNER: Yes, sir. Chairman Galassie,

3 Members of the Board, we thank you for the opportunity to

4 be here before you today with our message for you. We also

5 would applaud your endurance this day. We appreciate it.

6 We'll try and be to the point with our comments. However,

7 this is an extremely important project not only to our

8 organization but to our community and the communities we

9 serve.

10 I think it's important you understand the

11 underlying issues for the Metro East, which in some cases

12 are substantially different from many of the applications

13 that you have heard today and made here at other times.

14 I want to thank also Jack Axel, Joe Lanius,

15 Honey Skinner, Billy Page. Joe is the Vice-President of

16 Finance, and Jack is with Axel Associates, and we'll move

17 on. I just want to say thank you to the Staff for the

18 report. We appreciate their work.

19 My name is Mark Turner. I'm the President and

20 CEO of Memorial Hospital. Southwestern Illinois -- we are

21 the Metro East side of St. Louis. So, we are -- our

22 hospital is about 10 to 12 miles from the river. St. Louis

23 sits on the river. The community is very diverse. As

24 Mayor Vernier pointed out in his testimony, I-64 really

1 separates our county, St. Clair County. It runs east and
2 west and really becomes kind of dividing of north-south
3 inside the county.
4 We serve a number of communities. The
5 population of St. Clair County is 270,000. Population of
6 Belleville is 45,000. We are the largest hospital in the
7 Metro East. We are your representative hospital in terms
8 of being the Hospital Control Center hospital, meaning that
9 in times of disaster, we are the coordinating hospital, and
10 in my tenure as the CEO, we have twice handled the
11 evacuation of other facilities due to whatever untoward
12 events have occurred in those facilities, coordinated that.
13 We also are in the service area for east
14 St. Louis. As many of you are aware, Kenneth Hall has
15 closed the emergency department, closed about 30 days ago,
16 40 days ago. I cannot give you specific numbers, but our
17 emergency department leadership tells us that we are seeing
18 a significant increase of residents from East St. Louis
19 come to our institution.
20 We're also -- in 2003 through 2005, we're
21 described as the epicenter of the malpractice crisis in the
22 United States. Many of you may be aware of this. In fact,
23 the local newspaper published an article in that time
24 frame, mentioning 160 physicians had fled our county and

1 the neighboring counties to the north, Madison County. The
2 Metro East, by the way, that term describes about 7
3 counties with St. Clair and Madison County to the north
4 being the larger-populated counties.
5 160 physicians. We took it on our shoulders
6 as an organization to create models to keep physicians in
7 the community. We currently employ 65-plus physicians,
8 about 25 mid-level providers which is a very, very large
9 network for our community. This is the only way we could
10 keep and maintain neurosurgery services and orthopedic
11 services and the like.
12 With that mass exodus, we still have
13 malpractice environment. Recruitment is still a
14 significant issue, and I'll come back to that in a minute.
15 We are a Magnet-accredited hospital. That is an
16 accreditation by a nursing credentialing center, which
17 recognizes nursing excellence. Only 6 percent of the
18 hospitals in the United States are accredited. We are the
19 only hospital south of Springfield, Illinois with that
20 accreditation. We recently received a Health Grades Award
21 as the only Cardiac Surgery Center of Excellence in the
22 greater St. Louis market. We're the largest acute provider
23 of Medicaid patients in the area, with 15 percent of our
24 admissions being Medicaid-covered individuals, another 4 to

1 5 percent uninsured. We are a full-service community
2 hospital. We do neurosurgery, we do open heart surgery.
3 Again, we are the pillar, if you will, of our community
4 that we serve. I mentioned the regional Hospital Control
5 Center.
6 Here is the process that we've gone through --
7 and I'm trying to get to the point and be brief. We have
8 looked forward to planning. We engaged McManus Consulting
9 firm. We also engaged, as a follow-up to that, HDR, the
10 largest healthcare architectural firm in the United States.
11 We have identified a need for all private rooms. I'm sure
12 that the Board is very, very familiar with this, the need
13 to reduce infections by going to all private rooms. I
14 think all of my colleagues around the country have plans on
15 how to become an all-private-bed facility. So I'll come
16 back and answer those questions, if they need be. So
17 that's our primary objective.
18 The other objective, I think, is very, very
19 important as well, is that as an Illinois institution, we
20 are seeing about 30 percent of the hospital admissions in
21 our market that end up going to St. Louis for their care.
22 In fact, we would exclude tertiary care, and we do provide
23 some tertiary care, but we are more of a community hospital
24 setting. When you look at just primary and secondary care,

1 which is the basic community hospital services, the average
2 daily census in St. Louis hospitals averages out, according
3 to McManus Consulting, to be over 120 patients a day. 120
4 patients an on any given day are in a hospital bed, when
5 you combine all of the St. Louis institutions. We want to
6 keep those patients in our state with our services going
7 forward.
8 Growth projected to increase over 5 percent
9 over the next years with out any significant change,
10 without any change in market share. In fact we're not
11 projecting overly significant change in population.
12 However, our population in our community is aging rapidly.
13 Again, keeping nothing else changed, we're anticipating in
14 five years a growth in our average daily census of 11
15 patients per day with everything going on there.
16 We are the largest emergency department. And
17 this is prior to the impact of Kenneth Hall closing, these
18 statistics. We serve -- the next largest hospital in terms
19 of emergency department services only 56 of the patients
20 that Memorial does. Of those patients we see in the
21 emergency department, 12 percent are uninsured, 31 percent
22 are on Medicaid.
23 Our current location -- what we're trying to
24 do here, to come back to this, is we're trying to create an

1 all-private-bed facility. We have about 218 patient rooms.
2 We're licensed for 316 beds. Our peak census in any given
3 year is going to fluctuate and be somewhere between 278 and
4 280 patients. We to not have the rooms to be an
5 all-private-room facility. Our current location is a
6 75-acre site that's heavily utilized already. Secondarily,
7 it is a V-shaped piece of property and, unfortunately, all
8 of our actual hospital facilities are in the bottom of that
9 V. So, when we begin to look at expansion, we're going to
10 be taking out utilities. We'll probably be taking out a
11 public street. In fact, let me go back. HDR -- we
12 completed a long-range planning need for our community,
13 working through 2006 and 2007, that was adopted by our
14 Board. Follow-up to that we did a masters facility plan.
15 We anticipated in that masters facility plan initially
16 doing a patient tower on our campus to achieve the
17 all-private-bed status. As we worked our way through that,
18 it became very, very apparent that we on would not be able
19 to do this in a cost-conscious manner. In fact, as I also
20 mentioned, based on the V-shape of our property, we also
21 have something that prior to moving to southwestern
22 Illinois I was not familiar with. The area is heavily
23 under mined, coal mines underneath our existing campus. A
24 160 feet down is a six-foot seam. In fact, I came to this

1 Board about 18 months ago for approval of the orthopedic
2 and neuroscience center that Mayor Eckert. That's a $25
3 million project, and we did not meet the construction
4 criteria there, as well as financial ratios, at that time
5 and part of the reason why we did not meet the construction
6 criteria was because we had to pump concrete into the coal
7 mine, and that's how we chose to handle it. As we got into
8 that, we found out that coal mine is filled with water,
9 which makes the coal shaft a little more unstable, based on
10 what I'm told. I'm not an engineer. I'm just telling you
11 what the engineers told me.
12 So, the bottom line, when we look at becoming
13 an all-private-bed facility, we went down the road and
14 looked at all of our costs. We think we can't get it done
15 for less than $180 million. The emergency department is
16 going to have to be expanded. We have the coal mine
17 situation. We are so spread out we have to double the
18 power plant, because the power plant can't send heated
19 water as far away as it would have to, because it's at the
20 very bottom of that V-shape in our property.
21 Simultaneously with the planning process that
22 we worked through, we investigated other pieces of
23 property. Obviously, we're very aware of the out-migration
24 of patients in our community. We went through the process

1 and thought we were going to purchase a 100-acre site from
2 the Shiloh community, and during the process, the word got
3 out that we were searching for property. Another developer
4 came in and acquired the property we were looking at and
5 then shopped it in St. Louis and one of the large St. Louis
6 system bought that property. We were given the opportunity
7 to bid, but when the price was double what we thought it
8 should go for, we walked away from that.
9 We then spent 2007, 2008 acquiring 7 different
10 parcels, putting together, in Shiloh, to accommodate a
11 95-acre site for future needs. While this was going on, we
12 were also completing our master facilities planning
13 process, and as I pointed out to you, realized that we
14 cannot achieve all-private-beds on our campus, and chose to
15 then look at doing something with the Shiloh property.
16 After several years of planning and acquiring the
17 property -- and with some of those parcels, even though we
18 acquired and closed on the property in 2008, some of the
19 residents who lived in those homes said, "We'll sell you
20 the property but we need to live here for a couple of
21 years", and the last property was vacated in the spring of
22 2010. Therein lies the timing of our process as we've
23 worked forward.
24 Obviously, healthcare reform, the economy and

1 access to capital has been an issue as we've worked our way
2 through it. We think we've achieved all of the goals of
3 our project. It's affordable. It's the best use of
4 community resources, because instead of approximately $180
5 million, we're projecting to come in at $118.6 million.
6 All right. Keep in mind our emergency department. We
7 expanded it to the tune of $4.5 million between 2007 and
8 2009. Yes, it was a two-year project. Why? Because we
9 are locked. All right. I have to expand it and renovate
10 it while moving other services around. As we grow, working
11 our way through this, we are already outgrowing that
12 emergency department expansion. So, it's now spend
13 significant money knocking the walls out, brick and mortar
14 or creating an alternative site as part of this hospital
15 proposal we have before you today in Shiloh.
16 We're excited about it. We think, again, it
17 improves access to care. Anytime you have 30 percent
18 out-migration in a community, that is a key issue. Again,
19 it's not -- for the State of Illinois and this Board, these
20 are not patients that are going to another hospital in
21 Illinois. They're going to services in St. Louis, and we
22 would love to keep those patients here.
23 We want to provide all private rooms. We want
24 to enhance the patient experience and patient satisfaction.

1 I would tell you that you're welcome to look at
2 hospitalcompare.org and compare all of the Metro East
3 hospitals, and you'll find that we are and have been the
4 leader in patient satisfaction. We are and have been the
5 leader in most of the patient quality measures that CMS
6 measures there as well. It will reduce out-migration of
7 residents to St. Louis.
8 We've been very conservative on our
9 projections. Again, we break hospital care down in the
10 industry, most people do, by primary hospital care, which
11 is the very basic, secondary hospital care, which is also
12 typically done at a community hospital, tertiary and then
13 quaternary. We are not projecting any change in tertiary
14 and quaternary care. We're only projecting that we would
15 obtain 25 percent of the primary and 15 percent of the
16 secondary diagnosis patients that are going to St. Louis
17 right now. So, very conservative estimate to make this
18 work.
19 At the same time, it was very important to us
20 and what I think, if I'm sitting in your shoes, one of the
21 most important questions I would be asking, if you're
22 familiar with our community, is are we committed to our
23 current location? Over the last 10 years we have spent on
24 average $15 million a year in capital investments in that

1 facility, either through equipment, services, construction,
2 whatever the case may be. Currently under construction and
3 on schedule -- I may have jinxed it by saying that. But on
4 schedule at this point is a $25 million orthopedic and
5 neurosciences facility under way. We anticipate perhaps
6 some day coming back to you with a sister building. That
7 building site has a place for a sister building that we
8 would like to do some day. We want to achieve all private
9 rooms first. We're also going through a $5 million
10 renovation to our 108-bed, nationally recognized, awarded
11 skilled nursing facility. All of those stay on our primary
12 site. We are trying to achieve all private beds. We would
13 like to move this 94 of those beds to Shiloh, full-service
14 hospital being there. We would maintain a 216 beds at our
15 current site, all private rooms, and one of the things that
16 had been mentioned today, one of the things we want to make
17 very clear is that we have worked toward the Staff
18 requirement and the Staff position that the area is over
19 bedded. We are actually reducing our number of licensed
20 beds by 6 We are only doing this to achieve an
21 all-private-bed status.
22 Again, we want to improve access to care. We
23 are going to significantly improve access to emergency
24 care. One of the challenges we face -- and really our

1 whole community faces -- if you're on the north of side of
2 64, just the way the Roads run, it's very difficult to
3 access the hospitals that exist to serve that area. Our
4 cardiac surgery, neurosurgery and high risk OB will
5 continue to stay at our Belleville campus. We'll continue
6 to provide those services there.
7 In response to the State Agency Report, just a
8 few items. Forgive me for moving so quickly. I'm just
9 trying to be respectful of your time. A couple of things I
10 want to say there. The State Agency's Report indicates
11 that we don't meet the OB utilization, and we recognized
12 that by splitting the OB services. However, we don't want
13 to pull OB out of Belleville. We are a 53-year-old
14 community hospital, the only community-owned hospital in
15 the Belleville market. We're there to stay. We want to
16 continue to provide OB there. However, OB is part of the
17 services that are out-migrated, and we want to provide OB
18 services in Shiloh. So, we're trying to meet that need as
19 well.
20 The second issue that the Staff Report
21 identifies is the excess of med/surg beds. In fact, the
22 key point here is we're not adding med/surg beds. We're
23 reducing total beds by a total count of 6. So our license
24 would go from 316 beds to 310.

1 The other issue, as I mentioned, peak census
2 right now, 275 to 280, going up by 11. Let's round that
3 off and say just in five years, by the time this
4 institution would be open, we would see peak winter census
5 of 290 patients, something that, again, when you factor in
6 the fact that we're undermined, we are your Hospital
7 Control Center hospital for southwestern Illinois, our
8 region, and being undermined we are -- our number one
9 disaster that we plan for and we're told to plan for is the
10 earthquake issues related to the New Madrid Fault. If you
11 realize and understand that particular issue, we are in the
12 zone that would have supposedly devastating effects by that
13 and, of course, in our market tornadoes are also an issue.
14 But having all of our beds as your Hospital Control Center
15 on a ground that is undermine, with consideration to the
16 impact of New Madrid Fault, just seems to be something we
17 would like to correct going forward.
18 Again we're not leaving the site. We would
19 hate to expand on that situation.
20 CHAIRMAN GALASSIE: Mr. Turner, would you
21 feel comfortable moving to questions from the Board?
22 MR. TURNER: At your request, certainly.
23 MR. AXEL: Mr. Galassie, I was going to give
24 closing comments, and I can do that in 15 seconds. I'm

1 going to skip most of the things I was going to say.
2 CHAIRMAN GALASSIE: It's the late hour of the
3 day, but you shouldn't feel rushed. It's not fair to you.
4 MR. AXEL: That's perfectly all right. This
5 project as designed, because of the way the bed numbers
6 were put together -- and it's in Attachment 20-B(3) of the
7 application. This project will have no impact whatsoever
8 on the utilization of any other Illinois hospital, with the
9 exception of Memorial in Belleville. The incremental
10 patients coming from other facilities will be those
11 Illinois patients that are now leaving the State and going
12 to Missouri.
13 Thank you very much.
14 CHAIRMAN GALASSIE: Thank you.
15 MR. EAKER: I'd like to respond to that. How
16 do you know that.
17 MR. AXEL: Thanks for that question. Memorial
18 brought in McManus Consulting, which does work across the
19 country on patient origin, where patients are going for
20 their services. They used the data of the Missouri
21 Hospital Association, which is very similar to the data
22 from the IHA. They were able to identify all of the
23 patients in 2009 that went from the hospital's 21 zip code
24 service area to Missouri for their care. As Mr. Turner

1 mentioned, the coordinated care, the tertiary care, we
2 anticipate that is all going to continue to go. We were
3 able to identify how many of those patients are primary
4 patients. This is the cholecystectomy, the simple
5 pneumonia, typically relatively-short inpatient stays. We
6 believe that we can attract 25 percent of those patients, 1
7 in 4.
8 The second area of patients -- maybe the hip,
9 secondary level patients -- we think that we can attract 15
10 percent. So we're talking very conservative numbers here.
11 We're not saying 80 percent of the patients who are going
12 to Missouri now are going to come to us. It's not going to
13 happen. It will never happen. The hospitals in Missouri,
14 quite frankly, have great marketing efforts.
15 MR. BAKER: I grew up -- I was born and raised
16 in this area. All of my family live in this area. By your
17 own admission, due to the litigation of the area and
18 everything else, it's hard to get good doctors into your
19 area. It's been my experience that my family members and
20 all that go to the St. Louis area go because they want to
21 get the best doctors. So what would you -- what are you
22 proposing that you would be able to recruit doctors to this
23 facility in that climate.
24 MR. TURNER: Thank you. That's a great

1 question, and I appreciate the question very much.
2 First of all, let me tell you that we said it
3 was difficult but not impossible, and we are having
4 tremendous success recruiting those physicians. Of those
5 65 physicians that I mentioned, I can't give you an exact
6 number, but approximately half are new physicians that
7 we've been able to recruit since putting up this model. We
8 are having significant success -- Dr. Morton, Dr. Merritt,
9 who spoke to you today, those are all physicians that we
10 recruited since the malpractice crisis. Those are the two
11 toughest specialties to recruit to our area. Dr. Merritt
12 is already full. Wonderful personality has a lot to do
13 with that, tremendous skill set. Dr. Morton, as I
14 mentioned earlier or he mentioned, is an orthopedic
15 surgeon. That's the number one area of difficulty in the
16 country. So we're having tremendous success.
17 Our organization is clearly turning the tide
18 on out-migration. However, unfortunately out-migration is
19 growing, and we feel like community-wise, we have to
20 resolve this, and I'm appealing to an Illinois Board to
21 help assist our community, assist our organization in
22 keeping Illinois residents here, regardless of their
23 ability to pay, regardless of their class of insurance or
24 uninsured, and we're here to serve, and it's very, very

1 important, extremely important to me and our organization
2 that you understand we are not leaving Belleville. We are
3 staying. We are just going to provide all private rooms to
4 our Belleville residents and all private rooms to the other
5 residents who, for the most part, are already leaving our
6 community.
7 MR. SEWELL: What's the population of Shiloh?
8 MR. TURNER: Shiloh -- O'Fallon is
9 approximately 25,000. Shiloh is 12,600.
10 MR. SEWELL: What are you estimating will be
11 your payor mix at the Shiloh facility in terms of
12 Medicare/Medicaid.
13 MR. TURNER: Again, a very good question. We
14 anticipate it being very, very similar to what we have now.
15 MR. SEWELL: Do I have assurances from you
16 that there's no long-term plan to build up Shiloh and
17 eventually close Belleville?
18 MR. TURNER: You have long-term assurance,
19 sir. You don't invest $15 million a year, $25 million
20 right now under way, $5 million renovation on our nursing
21 facility -- in fact, part of this is when you look at the
22 financial ratios, as a not-for-profit hospital, a
23 community-owned organization, you put the money back in to
24 it. If we -- if we wanted to be a bank, we could have done

1 that. We could have not reinvested that $15 million,
2 invest $5 million a year for 10 years, and all of a sudden
3 that's quite a bit of money, $100 million put away, but
4 your facility is lacking. We've not done that.
5 MS. SKINNER: And also -- I was sworn as well.
6 I just note that that was one of the reasons we very much
7 wanted the Mayor of Belleville to be here and to speak to
8 his support and Belleville's support. We are looking for
9 as much public confirmation of our commitment, and we
10 wanted you to know that. I should also just mention to you
11 that this project is distinctive. There has never been an
12 application for a new hospital in Illinois that for which
13 there was no public hearing requested. That was not a
14 surprise to us. For three years, our partners in Shiloh,
15 O'Fallon, and Belleville have worked with us on this
16 project to keep our Belleville hospital healthy and in play
17 by having private rooms but not reducing access to
18 services.
19 The other reason we're different from every
20 other application for a new hospital is there has never
21 been an application before this Board that has proposed a
22 new hospital and has reduced the number of medical/surgical
23 beds. We have done that because we get it in terms of your
24 inventory, your desire not to add to excess. Even with our

1 growth and the role we play, our recruitment of physicians,
2 we wanted to come to you with a project that says, "We hear
3 your planning objectives."
4 MR. TURNER: I would also point out on the
5 public hearing phase we didn't want to overwhelm the Board
6 with 3,000 letters and bring 3,000 people here today,
7 although it is well within our ability to do so. We didn't
8 think you would appreciate it, although that's well within
9 our ability to do so. You have 27 letters of support from
10 physicians and all of -- all of the key area leaders. So,
11 this is a project that we believe we have complete
12 community support for.
13 Thank you.
14 CHAIRMAN GALASSIE: Board questions?
15 MR. BURDEN: Mr. Chairman? Thank you.
16 I'm impressed by what I hear but I'm also sort
17 of doubtful. You have attempted to handle -- this may well
18 not be KIOTI, but when you have one of the primary, highest
19 malpractice regions of the state of Illinois -- I knew that
20 from my 15 years of looking at all of the alleged
21 malpractice in the state of Illinois -- that problem hasn't
22 gone away. Are you attempting -- and must be salarying
23 your high-risk people, neurosurgeons are -- orthopedic
24 surgeons carry major tickets to protect themselves from

1 malpractice in Cook County, which is not that bad, but not
2 a hell of a lot better than from where you guys are. To
3 boot, I'm listening to 527 excess beds, and I'm being told
4 it won't affect the bed count. We have just gone through
5 two major, lengthy discussions earlier today where this was
6 a major issue regarding the vote of this Board. Now you're
7 asking us to turn completely around, recognizing the
8 situation you're in. It is indeed a difficult one, but
9 you're asking us to turn a blind eye to what we call our
10 standards, and I have a lot of questions I'm throwing out
11 there.
12 One, you got to guarantee so many years to get
13 a neurosurgeon to stay put. I know what it is in Chicago.
14 The head of neurosurgery at Northwestern is a personal
15 friend, and has lost three neurosurgeons in the last year,
16 people he's trained, and they're not coming down here. So,
17 I can speculate that you're going -- you don't have to tell
18 me if you don't want to, but I speculate you have to be
19 greasing the skids big time. You're building a facility, a
20 mousetrap, that I hope -- indeed, I would hope strongly
21 that you're going to be successful in this. But to me it's
22 rolling the dice big time, in view of what's going to be
23 coming in two years, unless mandated care gets thrown out
24 by our U.S. Supreme Court. That's another story.

1 You got to help me -- basic question: How the
2 hell do you keep 527 excess beds and convince us that we
3 should still vote for this project.
4 MR. AXEL: Absolutely. Dr. Burden, you always
5 bring up good questions. Thank you.
6 You brought up questions in two areas. One is
7 the over-bedding of the area, and the other is physician
8 recruitment and retention. We'll hit them both.
9 Unlike the two projects that you heard this
10 morning and well into the afternoon, we are not adding
11 beds. We are reducing the number of beds in the planning
12 area. Memorial in Belleville is dropping from 316 beds to
13 216 beds, a loss of 100 beds. We're putting 94 of those
14 beds in Shiloh. We're putting them out there, because in
15 order to convert Memorial to an all-private-room facility,
16 if we were going to do it on the campus, would be $180
17 million because of all of the issues that Mr. Turner
18 raised. This project, taking those beds and moving them
19 out, is $118 million. We're saving $80 million. So that's
20 the big distinction. We are not adding beds. In virtually
21 every corner of this state -- I think there's one planning
22 area in the entire state that isn't over bedded. We're not
23 adding to that. We are modestly reducing the number of
24 beds.

1 MR. BURDEN: What's going to happen to these
2 other institutions which we agonized over basically
3 earlier? St. Anthony's, 36 percent; Gateway Regional -- I
4 don't know anything about Granite City, 25 percent; St.
5 Joe's Hospital, wherever that is, 24 percent. These places
6 are ready to close. I'm surprised they're still open.
7 MR. AXEL: The real short answer is nothing is
8 going to happen to them, because if you -- looking at page
9 101 to the application, the way we identified the number of
10 beds that we were going to need -- "we" being Memorial --
11 whether they be Memorial Belleville, Memorial Shiloh, is we
12 took each zip code that contributes patients to us; we
13 looked at it on an age breakout; we took utilization rates,
14 which we were able to do for each zip code; we applied the
15 demographic changes, some zip codes increasing in number,
16 some zip codes actually going down in number. More
17 important, however, is the aging of the area. So what
18 we're doing is we're holding our market share of Illinois,
19 our market share of Illinois constant. We're not taking
20 from anybody else.
21 MR. BURDEN: Fellow Board Member Mr. Sewell
22 asked a key question. You guys are river boat gamblers.
23 Who the hell is going to recommend you to sign something
24 you're not going to pull off and be gone, and you mentioned

1 15 million, but that's a drop in the bucket when you look
2 at all of the things.
3 MR. TURNER: $25 million project under way
4 now, $5 million renovation. Guys, we're not pulling out.
5 That's why we have the Mayor of Belleville here today.
6 That's the message, and that's the number one question you
7 should be asking us. That is the most important question.
8 If you want follow-up documentation we're not leaving,
9 you've got it, because you would have to approve it. We
10 would have to come here. We are not going anywhere.
11 MR. BURDEN: I've been around here four and a
12 half years. Kenneth Hall, a hundred people and the mayor
13 came down from Springfield, guaranteeing that this ER will
14 stay open. Now I hear it's closed. Touchette Regional
15 Hospital was to be it's savior. That doesn't look very
16 healthy, 66 beds with 36 -- so the whole area is a very,
17 very complicated area. You guys are taking on a big, big
18 challenge here.
19 MR. TURNER: That's correct, and we need your
20 help to continue to succeed. I also want to answer the
21 question about the neurosurgery piece. In 2004, 2003 time
22 frame, we lost neurosurgery coverage. Two of our three
23 neurosurgeons stopped doing craniotomies because they
24 didn't have the coverage. Other neurosurgeons left the

1 community. We now employ three full-time neurosurgeons.
2 We pay market rate. Okay? But, yes, market rate for a
3 neurosurgeon is extremely expensive, and when you talk
4 about the financial ratios, part of what drives the recent
5 financial ratios that you're looking at is, one, loss on
6 investment return in 2008 and 2009 period, but also the
7 significant cost of reposition recruitment.
8 The up side of being very successful in
9 physician recruiting, as successful as we have been, is we
10 are meeting the community need. The down side is we're
11 covering the salaries of those physicians in their first
12 two, three, four years. Not many of our physicians are
13 busy as quickly as Dr. Merritt, talked about tonight, being
14 completely full. We're excited where we're going with
15 physician retention and recruitment.
16 CHAIRMAN GALASSIE: I'm going to try to move
17 this forward. Is the Board feeling we're ready for a vote?
18 MR. PENN: I have a question. Did you get
19 support from Scott Air Force Base for this project.
20 MR. TURNER: Scott Air Force Base we had
21 support from Congressman Costello, and if you're familiar
22 with how the arrangement works in our part of the state,
23 Congressman Costello is close to being single-handedly
24 responsible for maintaining the Scott Air Force Base, an

1 ongoing concern. It was slated to close during the BRAC,
2 the Base Realignment and Closure. So, we have his support.
3 Scott Air Force Base cannot provide letters of support,
4 their legal positions, for anybody. So that's just the
5 Federal government's position. We're there -- definitely,
6 I would tell you that we're here to support them. We have
7 a great working relationship with Scott Air Force Base, and
8 we have a great relationship with them, providing care of
9 their patients.
10 MR. PENN: I'm aware of your dilemma of people
11 going to St. Louis. I'm not aware of people going from
12 St. Louis to Belleville. In my job I work with people's
13 benefits. One of the problems we have is people being out
14 of network, going across the river and how we can keep the
15 patients in Illinois and provide them the best quality
16 service and I -- the plan that you're putting out here
17 today I truly applaud, because not only are you serving
18 Metro East area, but I know you're looking at Chester,
19 McLeansboro. I've talked to people as far away as Mt.
20 Vernon who had to go as far as St. Louis. If they can stop
21 before they cross that river, you're right, the revenue and
22 services can be maintained in our state, so I am aware--
23 MR. TURNER: It's good for Illinois on all
24 sides.

1 CHAIRMAN GALASSIE: Any other questions?
2 (Pause)
3 CHAIRMAN GALASSIE: Hearing none, I'll propose
4 a motion to approve Project 11-017 to establish a 94-bed
5 acute care hospital in Shiloh, Illinois, at a cost of
6 approximately $119 million.
7 MR. PENN: So moved.
8 MR. HILGENBRINK: Second.
9 CHAIRMAN GALASSIE: Moved and seconded. Roll
10 call, please?
11 MR. ROATE: Motion made by Mr. Penn, seconded
12 by Mr. Hilgenbrink.
13 Dr. Burden?
14 MR. BURDEN: I'm well aware that we're going
15 to have some very, very concerned prior applicants if we
16 vote along the ways of what you'd like to hear. I'm
17 concerned about that, because it's sort of like we're being
18 a little inconsistent, to put it mildly. But I guess I'm
19 just a little bit river boat in me, too. I will vote yes
20 on this, with tongue in cheek and fingers crossed.
21 MR. ROATE: Mr. Eaker?
22 MR. EAKER: I would like to pass for the
23 moment.
24 MR. ROATE: Justice Greiman?

1 MR. GREIMAN: Aye.

2 MR. ROATE: Mr. Hayes?

3 MR. HAYES: Yes.

4 MR. ROATE: Mr. Hilgenbrink?

5 MR. HILGENBRINK: I'd just like to comment

6 that I also applaud the applicant and appreciate the

7 complexities that they've addressed, and I vote yes.

8 MR. ROATE: Ms. Olson?

9 MS. OLSON: Yes. Well done. Thank you.

10 MR. ROATE: Mr. Penn?

11 MR. PENN: I am voting yes, and I applaud what

12 you did.

13 MR. ROATE: Mr. Sewell?

14 MR. SEWELL: Yes.

15 MR. ROATE: Chairman Galassie?

16 CHAIRMAN GALASSIE: Yes.

17 MR. ROATE: Mr. Eaker?

18 MR. EAKER: I will say I have real

19 reservations about some of your projections, but I'll vote

20 yes.

21 CHAIRMAN GALASSIE: Thank you very much.

22 This motion passes. Congratulations.

23 Again, we are terribly sorry for the hour.

24 We're approaching inhumane for members. We were trying to

1 get in Blessing Hospital. The remaining items on this
2 agenda are going to be deferred. We will advise you as to
3 a meeting date in approximately three weeks. One of the
4 dates we've thrown out already is 21st of July. I believe
5 that's a Monday -- Thursday. We will reconvene. Whether
6 it's here again or not we will figure that out. The
7 remaining items of the agenda will carry over to that as
8 well.
9 Prior to that, questions, comments or more
10 confusion.
11 We'll recess this meeting and then restart
12 again on the 21st, assuming that's the date. We can't
13 assure you of that date yet.
14 MS. SKINNER: Mr. Chairman, may I say
15 something?
16 CHAIRMAN GALASSIE: Yes, ma'am. Please do.
17 MS. SKINNER: I wrote a note to Ms. Avery I
18 just wanted to be very clear about. There is a project
19 that does not have opposition that is slated to hopefully
20 begin construction in two weeks, and I --
21 CHAIRMAN GALASSIE: Is there opposition --
22 the project is number --
23 MS. SKINNER: Glenbrook. I believe it's --
24 CHAIRMAN GALASSIE: It's -- Glenbrook is item

1 11-015. Is this any opposition on the Staff's part?
2 MR. CONSTANTINO: We received no opposition,
3 no.
4 CHAIRMAN GALASSIE: We have no opposition.
5 Any negatives?
6 MR. CONSTANTINO: Yes, there are negatives.
7 CHAIRMAN GALASSIE: Can you please advise us
8 of those, please?
9 MR. CONSTANTINO: We'll take 11-015, and then
10 the meeting is in recess.
11 Staff report on 11-015.
12 MR. CONSTANTINO: The applicant is proposing
13 to modernize the patient tower at Glenbrook Hospital in
14 Glenview, Illinois at a cost of approximately $36.5
15 million. The applicants will add a fifth floor on top of
16 the tower, bed tower, for a new 32-bed med/surg unit. The
17 project consists of 27 -- approximately 27,000 gross square
18 feet of new construction and 68,000 gross square feet of
19 modernization. There was no request for a public hearing
20 and no support or opposition letters received by the State
21 Agency.
22 The State Agency notes that the Glenbrook
23 Hospital's historic utilization does not justify the number
24 of the beds to be modernized. 2009 historical utilization

1 justifies 124 med/surg beds and not the 152 currently
2 authorized for this hospital.
3 CHAIRMAN GALASSIE: While we appreciate your
4 waiving your presentation, I think you'll have to share
5 with us the discrepancy between the med/surg bed.
6 (Oath given)
7 MR. SILVERSTEIN: Good afternoon, and thank
8 you for taking us at this late time. I'm Doug Silverstein,
9 and I'm the President of Northshore University Health
10 System's Glenbrook Hospital, and we are experiencing right
11 now 11 percent growth this year. We are going to achieve
12 the anticipated expected occupancy within the two years of
13 the construction with only 3 1/2 percent growth. So we
14 have no doubt that we are going to meet your guidelines
15 within the two-year completion of this project and,
16 especially, as I said, we're experiencing 11 percent both
17 admission and patient growth through 9 months of this
18 fiscal year.
19 CHAIRMAN GALASSIE: Staff comments on that?
20 MR. CONSTANTINO: Our rules require us to look
21 at the historical utilization for this criteria, and we
22 looked as the most recent 2009 utilization that we had, and
23 they could not justify it at target occupancy.
24 CHAIRMAN GALASSIE: Okay. Thank you.

1 Questions from the Board?

2 MR. BURDEN: My own personal opinion, it's in

3 my background and I go there, my family does, for medical

4 care. It's the exact opposite, frankly, of what we just

5 discussed down in Belleville. Obviously, the hospital

6 is -- I'm impressed by what's been done over there. I've

7 been to all of the hospitals in the Chicago area at one

8 time or another, and I recognize there has been some

9 conflict regarding the bed numbers, Mike?

10 MR. CONSTANTINO: Yes, sir. Right now they

11 have 152 authorized beds. Their 2009 historical

12 utilization will justify 124 beds, at the target occupancy,

13 85 percent.

14 MR. SILVERSTEIN: And those numbers have

15 clearly gone up since the 2009 period of time, as I said,

16 11 percent growth. We're going to meet it within the two

17 years of the completion of the project at just 3 1/2

18 growth, and we're growing at 11 percent at this point. All

19 this does at this point is get us to all private rooms. In

20 the middle of the week, we are now averaging between 30 to

21 40 of our patients in semi-private rooms, and as you all

22 know, nobody wants a hospital roommate. So it's something

23 that we think is very important to our community and,

24 certainly, as leaders in infection control as Northshore

1 Health System is, the first health system to implement
2 swabbing for MRSA, this is very important to us from a
3 quality standpoint.
4 MR. AXEL: This is also a hospital that
5 increased its bed size from 136 to the 152 beds in 2009.
6 The occupancy rate was calculated based on the larger
7 number, the 152 beds when, in fact, all of those beds
8 weren't available during that period. That's just the way
9 the bed need occupancy numbers are calculated.
10 MS. SKINNER: And all of this, by the way, is
11 part of the application and the record. This increased
12 utilization since 2009, although it's not -- the Staff is
13 not able to compare us to more recent information, we have
14 supplied it all as part of the record before you.
15 CHAIRMAN GALASSIE: Thank you.
16 Other questions from Board members regarding
17 this item, this application?
18 MR. PENN: Table 2, you list your charity
19 care, and I believe if I read this correctly from, 2007 the
20 total to 2009 is an increase of about 40 percent, from $6
21 million to $10 million.
22 MR. SILVERSTEIN: Yes. We continue to see our
23 charity care go up significantly. Obviously, changes in
24 the economy and with the closing of Holy Family Hospital in

1 our area have caused us to need to increase our charity
2 care.
3 MR. PENN: That is significant.
4 MR. SILVERSTEIN: Yes, it is.
5 MR. PENN: Very impressive.
6 MR. JONES: This is Mike Jones. I'm sorry.
7 I've got to ask this, as I see the Board is kind of rolling
8 their eyes. But on Table 2, your outpatient Medicaid
9 revenue jumps from $158,000 in 2008 to 8 million something
10 in 2009. Can you tell me what happened there? This is
11 Table 2.
12 MS. SKINNER: I'm looking at Table 2 right
13 now.
14 MR. JONES: Tell me it's a typo or something.
15 MS. SKINNER: I think that would be for Mike
16 to point out. As that table indicates, we have four
17 hospitals in our system and each one of them, you will see
18 substantial growth or material growth in both our Medicaid
19 patient and our charity care. The only difference -- the
20 only number that looks like it's coming down was actually
21 at Skokie Hospital, which we took over when it was
22 basically for sale from Rush, and that number, that older
23 number was not our number. But with regard to that bobble
24 in that one line item, I think that would be for Mike. It

1 looks like a typo to me.

2 MR. JONES: I'll check with Mike. Thank you.

3 CHAIRMAN GALASSIE: Any other questions on

4 the part of Board members? Again a reminder, you can vote

5 to approve, you can vote to reject, you can defer, or you

6 can place a condition on this application. Having said

7 that, can I have a motion to approve Project 11-015, to

8 modernize Glenbrook Hospital, located in Glenview, Illinois

9 at a cost of approximately $37 million?

10 MR. PENN: So moved.

11 MR. GREIMAN: Second.

12 CHAIRMAN GALASSIE: Moved and seconded.

13 MR. ROATE: Motion made by Mr. Penn, second by

14 Justice Greiman.

15 CHAIRMAN GALASSIE: Roll call?

16 MR. ROATE: Dr. Burden?

17 MR. BURDEN: Yes.

18 MR. ROATE: Mr. Eaker?

19 MR. EAKER: Yes.

20 MR. ROATE: Justice Greiman?

21 MR. GREIMAN: Yes.

22 MR. ROATE: Mr. Hayes?

23 MR. HAYES: Yes.

24 MR. ROATE: Mr. Hilgenbrink?

1 MR. HILGENBRINK: Yes.
2 MR. ROATE: Ms. Olson?
3 MS. OLSON: Yes.
4 MR. ROATE: Mr. Penn?
5 MR. PENN: Yes.
6 MR. ROATE: Mr. Sewell.
7 MR. SEWELL: Yes.
8 MR. ROATE: Chairman Galassie?
9 CHAIRMAN GALASSIE: Votes yes.
10 MR. ROATE: Nine votes in the affirmative.
11 CHAIRMAN GALASSIE: Motion passes.
12 Congratulations. Again, I sincerely want to apologize.
13 CHAIRMAN GALASSIE: The meeting is going to
14 recess.
15
16 END TIME: 6:30 p.m.
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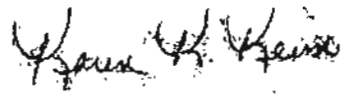
24

1 CERTIFICATE OF REPORTER

2

3 I, KAREN K. KEIM, CRR, RPR, a Certified Court
4 Reporter in the States of Illinois and Missouri, do hereby
5 certify that the proceedings in the above-entitled cause
6 were taken by me to the best of my ability and thereafter
7 reduced to writing; that I am neither counsel for, related
8 to, nor employed by any of the parties to the action, and
9 further that I am not a relative or employee of any
10 attorney or counsel employed by the parties thereto, nor
11 financially or otherwise interested in the outcome of the
12 action.

13

14 

15

16 KAREN K. KEIM

17 CRR, RPR, CSR-IL, CCR-MO

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