

REPORT OF PROCEEDINGS - 8-13-2013

1

1 S62945

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

5 REPORT OF PROCEEDINGS had at the hearing
6 of the above-entitled matter, taken at the
7 Bloomington-Normal Marriott Hotel & Conference
8 Center, 201 Broadway Street, Normal, Illinois,
9 on August 13, 2013, at the hour of 10:00 a.m.

10

11 BOARD MEMBERS PRESENT:

12 MS. KATHY OLSON, Chairperson;

13 MR. PHILIP BRADLEY;

14 DR. JAMES BURDEN;

15 SENATOR DEANNA DEMUZIO;

16 JUSTICE ALAN GREIMAN;

17 MR. DAVID PENN;

18 MR. RICHARD SEWELL.

19 ALSO PRESENT:

20 MR. FRANK URSO, General Counsel;

21 MS. ALEXIS KENDRICK, Board Staff;

22 MS. COURTNEY AVERY, Administrator;

23 MR. DAVID CARVALHO, IDPH Ex-Officio;

24 MR. BILL DART, IDPH Staff;

REPORT OF PROCEEDINGS - 8-13-2013

2

1 MR. MATT HAMMOUDEH, IDHS Ex-Officio;
2 MR. MIKE JONES, IDHFS Ex-Officio;
3 MR. MICHAEL CONSTANTINO, IDPH Staff;
4 MR. GEORGE ROATE, IDPH Staff;
5 MR. NELSON AGBODO, Health Systems Data Manager;
6 MS. CATHERINE CLARKE, Board Staff.

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

REPORT OF PROCEEDINGS - 8-13-2013

3

1	I N D E X	
2	CALL TO ORDER	6:3
3	APPROVAL OF AGENDA	7:22
4	APPROVAL OF MEETING TRANSCRIPTS, JUNE 26, 2013, MEETING	7:24
5	PUBLIC PARTICIPATION	8:16
6	POSTPERMIT ITEMS APPROVED BY THE CHAIRMAN (NONE)	34:18
8	ITEMS FOR STATE BOARD ACTION	
9	PERMIT RENEWAL REQUESTS:	
10	No. 12-027, Good Samaritan - Pontiac	34:24
11	No. 11-013, Bel-Wood Nursing Home	59:7
12	EXTENSION REQUESTS: (NONE)	
13	EXEMPTION REQUESTS:	
14	No. 017-13, Central DuPage ProCure Cancer Treatment Center	62:3
16	No. 018-13, Decatur Healthcare, LLC	72:8
17	ALTERATION REQUESTS:	
18	Palos Hills Surgery Center	74:24
19	DECLARATORY RULINGS/OTHER BUSINESS: (NONE)	83:7
20	HEALTH CARE WORKER SELF-REFERRAL ACT (NONE)	83:9
21	STATUS REPORTS ON CONDITIONAL/CONTINGENT PERMITS (NONE)	83:11
22		
23		
24		

REPORT OF PROCEEDINGS - 8-13-2013

1	APPLICATIONS SUBSEQUENT TO INITIAL REVIEW:	
2	No. 13-020, VHS Westlake Hospital	83:14
	No. 13-021, Franciscan St. James Surgery Center	94:11
3	No. 13-024, OSF St. Mary Medical Center	101:11
	No. 13-028, Kindred Hospital of Springfield	110:23
4	No. 13-029, Greater Peoria Specialty Hospital	111:2
	No. 13-010, FMC Schaumburg	127:7
5	No. 13-018, Luther Oaks, Inc.	135:17
	No. 13-026, Advocate Lutheran General Hospital	179:14
6	No. 13-025, University of Chicago Medical	
7	Center	198:4
8	No. 13-045, DaVita TRC Children's Dialysis	226:2
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		

REPORT OF PROCEEDINGS - 8-13-2013

5

1 CHAIRPERSON OLSON: I believe we'll
2 get started. Mr. Penn is on a call. He should
3 be back in the room in just a second.

4 Good morning, everyone, and welcome.
5 I'm sure you can all tell I'm not Dale
6 Galassie. This is my first stab at this. I'm
7 counting on the people to my right and left to
8 help me.

9 I would first like to acknowledge that
10 we have a team here from the Auditor General's
11 Office to observe our meeting today. We
12 appreciate their presence at the meeting.

13 I also want to explain the two-day
14 meeting because we will be meeting today and
15 again tomorrow. I felt that there were a lot
16 of issues that needed to be discussed, mostly
17 in executive session. Somehow that always
18 gets put at the very end of the day when
19 everybody is pretty much worn out and ready to
20 go home.

21 So just be aware that the Executive
22 Session is the first thing on the agenda
23 tomorrow morning, and it could be a rather
24 lengthy executive session. So you are

REPORT OF PROCEEDINGS - 8-13-2013

6

1 forewarned.

2 Okay. The first item on the agenda is
3 the Call to Order.

4 MR. ROATE: Mr. Bradley.

5 MEMBER BRADLEY: Here.

6 MR. ROATE: Dr. Burden.

7 MEMBER BURDEN: Here.

8 MR. ROATE: Senator Demuzio.

9 MEMBER DEMUZIO: Here.

10 MR. ROATE: Justice Greiman.

11 MEMBER GREIMAN: Here.

12 MR. ROATE: Mr. Hayes, absent.

13 Ms. Olson.

14 CHAIRPERSON OLSON: Here.

15 MR. ROATE: Mr. Penn.

16 MEMBER PENN: Here.

17 MR. ROATE: Mr. Sewell.

18 MEMBER SEWELL: Here.

19 MR. ROATE: Eight members present.

20 CHAIRPERSON OLSON: Seven. We have
21 an empty seat.

22 May I have a motion to approve the
23 agenda?

24 MEMBER DEMUZIO: Motion.

REPORT OF PROCEEDINGS - 8-13-2013

7

1 MEMBER SEWELL: Second.

2 CHAIRPERSON OLSON: Roll call vote,
3 please.

4 MR. ROATE: Mr. Bradley.

5 MEMBER BRADLEY: Yes.

6 MR. ROATE: Dr. Burden.

7 MEMBER ROATE: Yes.

8 MR. ROATE: Senator Demuzio.

9 MEMBER DEMUZIO: Yes.

10 MR. ROATE: Justice Greiman.

11 MEMBER GREIMAN: Yes.

12 MR. ROATE: Ms. Olson.

13 CHAIRPERSON OLSON: Yes.

14 MR. ROATE: Mr. Penn.

15 MEMBER PENN: Yes.

16 MR. ROATE: Mr. Sewell.

17 MEMBER SEWELL: Yes.

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

20 CHAIRPERSON OLSON: Thank you.

21 If everyone had a chance to read the
22 meeting transcripts from the June 26th
23 meeting, I'd like a motion to approve the
24 transcripts.

REPORT OF PROCEEDINGS - 8-13-2013

8

1 MEMBER DEMUZIO: So move.

2 MEMBER SEWELL: Second.

3 CHAIRPERSON OLSON: We'll do an aye
4 vote on that.

5 All in favor, aye.

6 (The ayes were thereupon
7 heard.)

8 CHAIRPERSON OLSON: Opposed, nay?
9 Motion passes.

10 Okay. Alexis, public participation, do
11 you want to go over that briefly for us,
12 please?

13 MS. KENDRICK: Yes. Thank you,
14 Chairman.

15 Good morning, everybody. We will now
16 begin the public participation segment of the
17 Board meeting, as required by the Open
18 Meetings Act. I'll just list some guidelines
19 to keep in mind.

20 Each speaker will be allotted a maximum
21 of two minutes to provide their comments about
22 agenda items listed on today's board meeting
23 agenda. Please understand that when you are
24 signaled to commence your comments, you must

REPORT OF PROCEEDINGS - 8-13-2013

9

1 conclude your comments. Inflammatory or
2 derogatory comments are prohibited.

3 The Board asks that you please make sure
4 that all comments are focused and relevant to
5 the specific projects on the current day's
6 agenda. Comments should not be personal and
7 not be disruptive to the Board's proceedings.

8 Please, prior to beginning your
9 statements, the speaker should identify the
10 project or agenda item that they are going to
11 speak on behalf of before initiating their
12 comments. Please spell your name for the
13 court reporter.

14 CHAIRPERSON OLSON: Thank you,
15 Alexis.

16 We will begin with Melanie Decker, Laura
17 Baue, David Sage, and Pastor Thomas Wirsing.

18 CHAIRPERSON OLSON: Please come
19 forward and be seated at the table at this
20 time.

21 Would you please use the microphone at
22 the table so the court reporter can hear what
23 the reviewer saying?

24 Please identify yourself and spell your

REPORT OF PROCEEDINGS - 8-13-2013

1 name for the court reporter.

2 MS. DECKER: Melanie Decker,
3 M-e-l-a-n-i-e, D-e-c-k-e-r.

4 Good morning. I'm here to oppose the
5 FMC Schaumburg Dialysis Unit. I am the
6 practice manager and primary nurse for
7 Dr. Vincent DiSilvestro, a nephrologist
8 practicing in Schaumburg.

9 Fresenius has proposed a project only
10 2 1/2 miles from the existing dialysis
11 facility in Schaumburg. The existing facility
12 received approval to add six stations to
13 accommodate 36 more patients last June.

14 We do not believe the establishment of
15 another facility in Schaumburg is an efficient
16 distribution of dialysis services.

17 Generally, improved access to dialysis
18 service is something we fully support.
19 However, this project will not provide an
20 appropriate distribution of services in the
21 Planning Area HSA7. The planning area covers
22 a broad geographic area.

23 When an excess of stations is created in
24 Schaumburg, patients in other distant parts of

REPORT OF PROCEEDINGS - 8-13-2013

11

1 Cook County and DuPage will have difficulty
2 accessing these stations.

3 Furthermore, 13 of the 19 facilities
4 within 30 minutes of the proposed facility are
5 underutilized, which is likely one of the
6 reasons the Board denied the project last
7 October. That is two-thirds of the
8 facilities.

9 Five of these underutilized facilities
10 are owned by Fresenius. These include Rolling
11 Meadows, Palatine, Downers Grove, Des Plaines,
12 and Glendale Heights. Of these, the
13 Des Plaines facility just opened, and Glendale
14 Heights was just approved in June and opened.

15 All of these facilities could easily
16 accommodate the patients identified in their
17 application. The existing facility in
18 Schaumburg is sufficient to address
19 Schaumburg's needs, and as such, we ask that
20 the Board deny the project.

21 Thank you.

22 CHAIRPERSON OLSON: Thank you,
23 Ms. Decker.

24 PASTOR WIRSING: Pastor Tom

REPORT OF PROCEEDINGS - 8-13-2013

12

1 Wirsing, W-i-r-s-i-n-g.

2 Good morning to the members of the Board
3 and Staff. I'm the senior pastor of Trinity
4 Lutheran Church located at 801 South Madison
5 in Bloomington. Thank you for the opportunity
6 to speak in support of the Luther Oaks
7 project.

8 As a Lutheran pastor, I have to tell you
9 how important it is for the members of the
10 community to have access to a faith-based
11 provider of skilled care services. The new
12 Luther Oaks facility will give area residents
13 the option of receiving their care in a place
14 that cares for their spiritual needs as well
15 as their physical needs.

16 There are a number of members of Trinity
17 who are already residents at Luther Oaks. So
18 I know firsthand the exceptional care that is
19 given to its residents by the Luther Oaks
20 staff.

21 I want to share with you a story that I
22 experienced that I think illustrates how
23 important Luther Oaks is to their residents.

24 I'm a part of a circle of pastors who

REPORT OF PROCEEDINGS - 8-13-2013

13

1 provide weekly worship services at the Luther
2 Oaks facility; and during one of those
3 services, I asked the people attending what
4 they were thankful for. The first thing out
5 of many of their mouths was they were thankful
6 for Luther Oaks and how blessed they are to be
7 living there.

8 It's important to our community to have
9 a place where people can receive the care they
10 need as they transition through the later
11 phases of life. The ability to receive the
12 continuum of care in one location is critical
13 to the residents, as it gives them the peace
14 of mind that they will not be separated from a
15 spouse or their support network as their
16 health changes.

17 For all these reasons, I ask the Board
18 to please approve Luther Oaks' request for a
19 permit to build a skilled nursing facility on
20 its campus.

21 CHAIRPERSON OLSON: Thank you,
22 Pastor Wirsing.

23 MS. BAUE: Laura Baue, B-a-u-e.
24 I'm President of the Luther Oaks Residents

REPORT OF PROCEEDINGS - 8-13-2013

14

1 Association.

2 On behalf of the residents of Luther
3 Oaks, I'm asking that you approve our
4 application for a skilled care facility.

5 Like most residents, my husband and I
6 took a giant leap of faith when we placed our
7 futures and our fortunes in the hands of the
8 Luther Oaks continuing care community.

9 Like most residents, we made the
10 decision to control where we spend the rest of
11 our lives. We do not want to risk being in a
12 crisis and face placement based on
13 availability of space. Also, we want to spare
14 our children the burden of such
15 decision-making.

16 Now, we've been at Luther Oaks for six
17 years. Most of us see fellow residents more
18 than we see family. New friends have become
19 our support system.

20 Moreover, we have grown to trust the
21 competence and compassion of the management
22 staff of our community, but many of us have
23 been frustrated and fatigued getting to and
24 from the off-site physical therapy. We've

REPORT OF PROCEEDINGS - 8-13-2013

15

1 been saddened when residents were isolated
2 from friends who no longer drive. We've been
3 devastated when spouses were separated because
4 one of them required skilled care, and it was
5 very disconcerting when a neighbor with no
6 family advocate confided "That nursing home
7 didn't care what I needed. They just did what
8 was best for them."

9 As a registered nurse and family member,
10 I have experienced area facilities where both
11 care and caring seem compromised by inadequate
12 staffing. No one wants to be in a nursing
13 home, but the reality is some of us will need
14 to be.

15 Given the choice, I will not place
16 myself in the hands of any local nursing home.
17 Instead, I will seek out a faith-based
18 not-for-profit facility.

19 Now you are being asked to determine
20 whether plans to remain in our home community
21 will be realized. Our futures and our
22 fortunes are in your hands. We implore you to
23 handle with care and approve the application
24 for our skilled care facility.

REPORT OF PROCEEDINGS - 8-13-2013

1 Thank you.

2 CHAIRPERSON OLSON: Thank you,
3 Ms. Baue.

4 MR. SAGE: Good morning, Members of
5 the Board and Staff. My name is David Sage,
6 and I'm the Alderman of Ward 2 in Bloomington,
7 Illinois. The spelling on my last name is
8 S-a-g-e.

9 I am here today in support of Luther
10 Oaks' request for a permit to build a new
11 36-bed skilled nursing facility.

12 I have served the residents of Ward 2
13 since 2007, which is the same year that Luther
14 Oaks originally constructed the
15 independent-living and assisted-living units
16 on its campus. I can tell you firsthand how
17 excited the community was for the new Luther
18 Oaks campus, not just because of the great
19 care they provide but because of the impact on
20 the local economy.

21 Since it opened its doors in 2007,
22 Luther Oaks has been a great neighbor and also
23 an asset to the community because of the jobs
24 it creates and the family members and visitors

REPORT OF PROCEEDINGS - 8-13-2013

17

1 it brings to the area.

2 The viability of Luther Oaks is
3 dependent on receiving approval to build its
4 new skilled nursing facility. I know from
5 speaking with area residents how important it
6 is to have a senior community in which
7 residents can live independently but also
8 transition to skilled care should that need
9 arise.

10 Failure to add the skilled care
11 component could jeopardize the future of
12 Luther Oaks, which would be incredibly
13 detrimental to our community.

14 I'm asking you to please approve this
15 project for the many benefits it will provide
16 to the residents of the community served by
17 Luther Oaks.

18 Thank you.

19 CHAIRPERSON OLSON: You may leave.

20 Can I get somebody to move that table
21 over so we don't destroy the court reporter's
22 neck? She's scrunching her neck.

23 Thank You.

24 I'll call Herm Harding, Cindy Wegner,

REPORT OF PROCEEDINGS - 8-13-2013

18

1 Janice Kindred, Mark Silberman, and Tim
2 Tincknell.

3 Please remember to state your name, and
4 state which project you are speaking on behalf
5 of. Thank you.

6 MR. HARDING: Good morning. I'm
7 Herm Harding. My last name is H-a-r-d-i-n-g,
8 first name Herm, H-e-r-m.

9 CHAIRPERSON OLSON: I don't believe
10 your mic is on, Mr. Harding.

11 Can you turn that microphone on?

12 MR. HARDING: I think it's on.
13 I'll start again.

14 I want to thank you all for the
15 opportunity to speak in support of the Luther
16 Oaks project. I'm a resident of Luther Oaks.
17 I've been there 4 1/2 years.

18 My wife Evelyn, my wife of 62 years, has
19 had Parkinson's disease for 22 years and had
20 deep brain surgery eight years ago. About 18
21 months ago, she started to have considerable
22 weakness, quickly losing control of her arms,
23 legs, and general strength. Her breathing was
24 erratic.

REPORT OF PROCEEDINGS - 8-13-2013

19

1 After undergoing nine hours of extensive
2 reconstructive surgery for spinal compression
3 of the neck, we were forced to place her in a
4 facility away from Luther Oaks, about a half
5 hour away from our home.

6 For five months I traveled daily to
7 share some meals with her, read daily
8 devotions, share family news, and compliment
9 her on her progress. It was important that
10 she be comfortable knowing that things were
11 okay at home and she didn't need to worry
12 about me or any of our family.

13 Frequent moves to new locations and
14 constantly receiving services from different
15 people can be interpreted by patients that
16 things are not going very well and they are
17 not progressing.

18 If my wife had been able to receive
19 skilled care at Luther Oaks, she would have
20 had the entire support network with her as
21 encouragement, and she would have been
22 receiving care from a familiar staff, a group
23 of people that she knew and trusted.

24 This was an incredibly difficult time

REPORT OF PROCEEDINGS - 8-13-2013

20

1 for both of us. We would not want anyone else
2 to have to go through this, being separated
3 from a loved one during a serious health
4 issue. This is why it's important to us and
5 other residents of Luther Oaks that this
6 project be approved.

7 Thank you.

8 CHAIRPERSON OLSON: Thank you,
9 Mr. Harding.

10 MS. WEGNER: Good morning. My name
11 is Cindy Wegner, W-e-g-n-e-r.

12 I'm speaking in protest of the Luther
13 Oaks project. I am the administrator of
14 Heritage Health in Normal. I am here today
15 with my colleague, Susan Holifield, who is the
16 administrator of Heritage Health in
17 Bloomington. Together we operate a combined
18 total of 275 licensed beds.

19 If approved, the addition of 36 beds at
20 Luther Oaks will have a detrimental impact on
21 existing providers. Additional beds are
22 simply not needed in Bloomington-Normal.

23 Both Heritage Health facilities have
24 been operating under the 90 percent target

REPORT OF PROCEEDINGS - 8-13-2013

21

1 utilization rate for a long time. As of
2 today, we have 75 empty beds available. My
3 facility's occupancy has averaged 74 percent,
4 and Susan's has averaged 76 percent here to
5 date. More beds in this community will only
6 create more challenges.

7 I've operated in this community for many
8 years and know the demand claimed by Luther
9 Oaks does not exist.

10 Despite the focus to serve their own
11 community, this would be an open admission
12 facility to serve private pay and Medicare
13 residents. 36 beds are significantly more
14 than Luther Oaks needs to serve its own
15 population and well beyond the continuum of
16 care allotment.

17 If approved, this facility will siphon
18 off private pay and Medicare residents from
19 the existing providers. Serving Medicare and
20 private pay is essential to both local
21 Heritage facilities. It helps us overcome the
22 losses we sustain from Medicaid reimbursement.

23 In the past year and a half, we have
24 added 43 private rooms between our two

REPORT OF PROCEEDINGS - 8-13-2013

22

1 facilities. We have done this by converting
2 two-person rooms into private rooms due to
3 lack of admissions. Despite the consolidation
4 of beds, we still almost always have empty
5 private rooms available.

6 The claim that Bloomington-Normal lacks
7 quality facilities is not true. Susan's
8 facility currently has a four-star overall
9 rating and a five-star rating for staffing.
10 Both of our facilities have four-star ratings
11 for quality outcomes, and our residents'
12 overall satisfaction with our health services
13 is consistently over 90 percent.

14 MS. KENDRICK: 30 seconds.

15 MS. WEGNER: Heritage has operated
16 in Bloomington-Normal for over 50 years. We
17 have taken care of thousands of residents of
18 all incomes and have continually reinvested in
19 our buildings.

20 Luther Oaks is asking for more beds than
21 necessary to serve their own population.
22 Approving this project will harm existing
23 providers and their employees. It is simply
24 not needed in this community.

REPORT OF PROCEEDINGS - 8-13-2013

23

1 Thank you.

2 CHAIRPERSON OLSON: Thank you,
3 Ms. Wegner.

4 MS. KINDRED: Good morning. My
5 name is Janice Kindred, J-a-n-i-c-e
6 K-i-n-d-r-e-d, and I am the administrator of
7 Bloomington Rehabilitation & Health Care
8 Center.

9 Bloomington Rehabilitation & Health Care
10 Center is a 78-bed skilled nursing facility
11 that has served the Bloomington community for
12 more than 40 years. Over those 40 years, we
13 have employed hundreds and hundreds of
14 hardworking local caregivers. We have
15 provided care for hundreds, thousands of the
16 community's seniors needing long-term care.

17 I rise today in opposition to the Luther
18 Oaks project. I would like to use my short
19 time to address two arguments contained in the
20 applicant's written arguments, the first and
21 most important being the claim that the
22 project will have a negligible impact on other
23 area providers.

24 This is simply not the case, not for my

REPORT OF PROCEEDINGS - 8-13-2013

24

1 facility nor other facilities in the area. It
2 is my understanding, based on the capacity
3 level of other area providers, that there are
4 currently more than 400 unutilized beds in the
5 planning area. That would seem to clearly
6 demonstrate to me that there is no need for 36
7 more beds in the area.

8 Peterson Health Care has owned
9 Bloomington Rehabilitation & Health Care
10 Center since October of 2005. The historical
11 average census of my 78-bed facility during
12 that time frame is 44 occupied beds. This is
13 an average of 56 percent of occupancy.

14 To say this proposed facility will have
15 a negligible impact on my facility is simply
16 not true. If the project is approved, it will
17 have a huge impact on my facility and many
18 others.

19 Luther Oaks describes referring 19
20 patients a year to area providers, which means
21 all of the remaining patients they expect to
22 serve will come at the expense of other area
23 providers.

24 This is not about protecting market

REPORT OF PROCEEDINGS - 8-13-2013

25

1 share. It is about the lack of need for
2 another facility. The impact of 36 beds could
3 jeopardize the very existence of some of these
4 facilities.

5 The second argument and one that is
6 really offensive to me, my hardworking staff,
7 and, I am sure, to all other long-term care
8 professionals in the area is the argument that
9 the facility will increase access to
10 high-quality skilled nursing care in the
11 community. Ten to 13 facilities in the GSA
12 have a Medicare star rating of three or less.

13 Does the Board really believe the 13
14 facilities in the Bloomington area are
15 providing low-quality care? I certainly do
16 not believe that.

17 I certainly don't have time today to
18 dissect the five-star rating system. However,
19 I submit this says more about the flawed
20 five-star rating system than it does about the
21 care being provided by all the great
22 facilities in the planning area.

23 I would ask the Board to research the
24 information published by the Illinois Health

REPORT OF PROCEEDINGS - 8-13-2013

26

1 Care Association, Life Services Network, and
2 the American Health Care Association.

3 In closing, thank you for allowing me to
4 take the time to speak to the Board this
5 morning. I urge you to deny the Luther Oaks
6 project. There is simply no need for such a
7 project in the area, and the addition of 36
8 beds in the planning area will harm the
9 providers already struggling to succeed.

10 Thank you.

11 CHAIRPERSON OLSON: Thank you,
12 Ms. Kindred.

13 MR. SILBERMAN: Good morning. My
14 name is Mark Silberman, S-i-l-b-e-r-m-a-n.
15 I'm here to speak today in opposition to
16 Project 13-018, the Luther Oaks project.

17 The two areas I want to discuss with the
18 Board today relate to the level of uncertainty
19 in this project's application and an issue
20 with regards to the continuum of care.

21 There are several aspects of this
22 application that have a level of uncertainty
23 that I would ask the Board to seek
24 clarification on before approving or perhaps

REPORT OF PROCEEDINGS - 8-13-2013

27

1 even considering this project.

2 The proposed zoning, the land that's
3 proposed for this site isn't currently zoned
4 to allow for this project. They have
5 expressed an intent to seek zoning; but as
6 anyone knows, there's certainly no guarantees
7 that the zoning would eventually be approved.
8 Since this is land already owned by Luther
9 Oaks, there's no reason not to pursue that.

10 Additionally, with regard to the
11 financing, there was additional information
12 submitted recently that shows they're
13 considering a broad range of financing, some
14 of which, if it were utilized, would actually
15 constitute a modification of the proposed
16 project.

17 Therefore, rather than risking the
18 project being approved and then have to come
19 back and seek modification of the financing,
20 we would ask this Board to please consider
21 some clarity with regards to the financing.

22 The last area which really highlights an
23 area of uncertainty is the proposed referrals.
24 The vast, vast majority of referrals that have

REPORT OF PROCEEDINGS - 8-13-2013

28

1 been identified are from one group that are
2 purely conditioned on the facility maintaining
3 a four-star rating under the CMS system.

4 The circumstances are such where quality
5 facilities providing quality care have proven
6 to be unable to maintain a four-star rating.
7 Ten of the 13 facilities in this community
8 have not maintained a four-star rating.

9 Therefore, if you look at the proposed
10 referrals, which by their own admission won't
11 be sent to this facility without maintaining a
12 four-star rating, there's a real question as
13 to whether or not approval of this project is
14 simply going to result in a 14th facility
15 that's being underutilized in this community.

16 The second issue relates to the
17 continuum of care. All of the public comments
18 that you heard and all of the comments
19 proposing this project in the application
20 relate to a continuum of care variance -- or
21 excuse me -- completing the continuum of care.

22 MS. KENDRICK: 30 seconds.

23 MR. SILBERMAN: Thank you.

24 This strategic decision was made by

REPORT OF PROCEEDINGS - 8-13-2013

29

1 Luther Oaks when they established the CCRC to
2 establish a community without including
3 skilled nursing care. They are entitled to
4 make that decision. It's a strategic decision
5 which allowed them to establish this campus
6 without having to come before this Board.

7 But now that they are here, this isn't a
8 question of what's in Luther Oaks' best need.
9 This isn't about their commitment or quality
10 of care. It's about the need in the
11 community.

12 There's no question that a strategic
13 decision to establish this campus without a
14 skilled nursing facility -- this Board has to
15 look -- there is not a single facility within
16 a half an hour that meets this Board's
17 criteria for utilization. There are hundreds
18 and hundreds of vacant beds.

19 While we respect the fact that they may
20 want to complete the continuum of care, if
21 that's their priority, let them submit a new
22 application utilizing the variance, which
23 would result in a smaller project to meet the
24 needs of their campus.

REPORT OF PROCEEDINGS - 8-13-2013

30

1 MS. KENDRICK: Please conclude your
2 comments.

3 MR. SILBERMAN: Otherwise, what
4 they're doing is proposing to meet a need in
5 this community that doesn't exist.

6 Thank you.

7 CHAIRPERSON OLSON: Thank you,
8 Mr. Silberman.

9 MR. TINCKNELL: Good morning. I'm
10 Tim Tincknell, T-i-m T-i-n-c-k-n-e-l-l,
11 administrator with DaVita, speaking on behalf
12 of Brian Stahulak, S-t-a-h-u-l-a-k,
13 administrator with the new Children's Hospital
14 of Chicago.

15 I am pleased to support DaVita's
16 proposal to relocate TRC Children's Dialysis
17 Center, as it will afford our patients
18 continued access to excellent dialysis care.

19 I am the Administrator of Transplant,
20 Hematology, and Oncology Services at Ann &
21 Robert H. Lurie Children's Hospital of
22 Chicago. As the largest pediatric provider in
23 the region with a 130-year legacy of
24 excellence, kids and their families are at the

1 center of all that we do.

2 We have the region's largest pediatric
3 kidney diseases (pediatric nephrology) team,
4 caring for more than 4,000 infants, children,
5 and adolescents each year. Our division
6 offers a full scope of care, including
7 dialysis and kidney transplantation for
8 children with kidney failure.

9 Children can also receive multiorgan
10 transplantation such as liver-kidney
11 transplantation for oxalosis or polycystic
12 kidney disease.

13 Our outcomes rank among the top centers
14 in the United States for both transplant and
15 dialysis. Our Pediatric Kidney
16 Transplantation Program continues to rank
17 among the nation's ten best pediatric
18 programs, and it's the largest of its kind in
19 Illinois.

20 Our relationship with DaVita as a
21 longtime operator of the in-center
22 hemodialysis unit affiliated with our hospital
23 is an integral part of our programs. DaVita's
24 TRC Children's Dialysis Center is one of two

REPORT OF PROCEEDINGS - 8-13-2013

32

1 dialysis facilities in the City of Chicago
2 solely dedicated to pediatric dialysis.

3 While other facilities may serve
4 pediatric patients, these facilities treat
5 adults, too. Children are physiologically
6 different from adults and require specialized
7 care.

8 As such, these facilities are not
9 appropriate for all pediatric patients,
10 particularly younger children; thus, ensuring
11 continued access to this facility is
12 essential.

13 In June 2012, Lurie Children's relocated
14 approximately 3 miles southeast of its former
15 location to its current location near the
16 Northwestern Memorial Hospital medical campus.

17 Due to the relocation of Lurie
18 Children's, the existing dialysis facility no
19 longer affords the same convenience for
20 patients and their families.

21 MS. KINDRED: 30 seconds.

22 MR. TINCKNELL: The existing
23 location, while convenient to the hospital's
24 former location, is in the middle of Chicago's

REPORT OF PROCEEDINGS - 8-13-2013

33

1 Lincoln Park neighborhood, which is heavily
2 congested and not proximately located to any
3 interstate highways.

4 A central location close to major
5 interstates is important to continue serving
6 pediatric patients throughout the Chicago
7 metropolitan area.

8 Furthermore, the existing facility has
9 no patient or visitor parking and no dedicated
10 patient drop-off location. As a result,
11 parents must park on the street with their
12 hazards on, assist their children with getting
13 in and out of the car and checked in for their
14 dialysis treatments. They must then return to
15 their cars and find parking in the
16 neighborhood.

17 While there are obvious safety concerns
18 during good weather, these hazards are
19 magnified during inclement weather. The
20 replacement facility will provide better
21 access to patients residing throughout the
22 Chicago metropolitan area. Additionally, it
23 will have dedicated parking for patients,
24

1 visitors, and staff.

2 MS. KINDRED: Please conclude your
3 comments.

4 MR. TINCKNELL: DaVita's proposed
5 facility will improve access to necessary
6 dialysis in our community.

7 DaVita is well positioned to provide
8 these services, as it delivers life-sustaining
9 dialysis services for residents of communities
10 like ours and has invested in many quality
11 initiatives to improve its patients' health
12 and outcomes; thus, I support the proposed
13 relocation of TRC Children's Dialysis.

14 Thank You.

15 MS. KENDRICK: That concludes our
16 public participation today.

17 CHAIRPERSON OLSON: The next item
18 of business is Postpermit Items Approved by
19 the Chairman.

20 Mr. Constantino?

21 MR. CONSTANTINO: There were none.

22 CHAIRPERSON OLSON: Thank you.

23 On to Permit Renewal Requests, Item
24 No. 12-027, Good Samaritan - Pontiac.

1 If there are representatives from Good
2 Samaritan - Pontiac, could they please come to
3 the table at this time? Good morning,
4 Gentlemen.

5 MR. HIATT: Good morning.

6 CHAIRPERSON OLSON: If you could
7 state your name and spell it for the court
8 reporter, she'll then swear you in.

9 MR. CLANCY: My name is Ed Clancy,
10 C-l-a-n-c-y.

11 MR. HIATT: My name is Richard
12 Hiatt, H-i-a-t-t.

13 (The witnesses were thereupon
14 duly sworn.)

15 CHAIRPERSON OLSON: You may
16 proceed.

17 MR. CLANCY: Good morning.

18 We were here last on June 26th with our
19 request to extend the condition on the CON
20 permit that you granted a while back. Part of
21 the granting of that request was that we file
22 a request for a CON permit renewal before
23 today's date, actually, and we filed that the
24 next day.

1 We are here on our first request to
2 extend the project obligation date. We'd like
3 to extend that from two years from the date of
4 the -- actually, we're here to extend the
5 project completion date. We'd like to extend
6 it two years from the project obligation date
7 of January 23, 2014.

8 If you'll note in the request, there was
9 a typo. We asked for January 23, 2016. We
10 also asked for July 23, 2016, but we're just
11 asking for the two years. So it's January 23,
12 2016. If you have any questions, we'd be
13 happy to answer them.

14 CHAIRPERSON OLSON: Thank you, sir.
15 I need to stop you for a second.

16 I apologize, Mr. Constantino. You're
17 supposed to go first.

18 MR. CONSTANTINO: That's quite all
19 right, Madam Chairwoman.

20 CHAIRPERSON OLSON: Thank you.
21 You're supposed to give me a sign.

22 Would you please give us the Staff
23 Report?

24 MR. CONSTANTINO: Thank you.

1 On July 23, 2012, the permit holders
2 were approved to discontinue a 122-bed
3 facility and establish a 122-bed facility in
4 Pontiac, Illinois, at a cost of approximately
5 \$14.6 million.

6 This permit was approved with a
7 condition to have financing in place by
8 December 2012 and a completion date of
9 August 13, 2013.

10 They are before you today asking for
11 approximately 36 months -- that's the
12 information we received, and that's the
13 information we sent to you -- which would make
14 the completion date July 23, 2016.

15 I learned this morning that evidently
16 they just needed -- they want the completion
17 date to be July 23, 2014.

18 Is that correct, Ed?

19 MR. CLANCY: January 23, 2016, two
20 years from then.

21 MR. CONSTANTINO: January now?

22 MR. CLANCY: Yes, there was both
23 dates in my request. It was a typo.

24 MR. URSO: Are you changing this as

1 we're going along?

2 MR. CLANCY: No.

3 In the request I first asked for
4 January 23, 2016, and at the bottom I
5 concluded with July 23, 2016. It was a typo
6 in the end. We were asking for January 23,
7 2016.

8 MR. URSO: Is that what you have?

9 MR. CONSTANTINO: I have July 23,
10 2016, and that's what I sent to the Board.
11 Evidently, they wanted January 23, 2016.

12 CHAIRPERSON OLSON: And that's the
13 proposed project completion date?

14 MR. CONSTANTINO: Yes, that's the
15 project completion date.

16 The Board has also approved on two
17 different occasions extending the financing
18 for this project. One is in December 2012 and
19 again June 26, 2013. Right now they must have
20 financing in place by December 31, 2013.

21 CHAIRPERSON OLSON: And you're in
22 agreement with that date?

23 MR. CLANCY: Yes.

24 MR. HIATT: Yes.

1 CHAIRPERSON OLSON: All right.

2 Questions from the Board?

3 Justice Greiman?

4 MEMBER GREIMAN: You had all this
5 time and you get no financing. Tell us about
6 your problems with financing.

7 MR. CLANCY: We're very close to
8 getting the financing. We hired a consultant
9 to file a feasibility and market report in
10 addition to the one we originally submitted to
11 the USDA. The USDA now has that new report.

12 The last we checked was several days
13 ago. They have everything. Everything is
14 good. They have no additional questions at
15 this point.

16 It's not a guarantee, but the consultant
17 that we hired has been working with the USDA
18 for a long period of time. When they invite
19 an applicant to submit an application,
20 basically they are saying at that point they
21 are going to loan the applicant money.

22 Right now everything is looking good.
23 Everyone from the USDA has given us positive
24 feedback on the application; and from what the

1 consultant tells us, the USDA makes a flurry
2 of closing those loans at the end of its
3 fiscal year, which is September. So we expect
4 to hear by September 30th of this year that we
5 have the loan.

6 It's not an approval process. USDA is
7 pretty unique. We're not the only one that
8 has applied for USDA loans. There have been
9 other applicants before you that have applied
10 for them. It's a long process. They don't
11 have rules like a HUD application, but we're
12 very confident that we will get that loan.

13 MEMBER GREIMAN: Well, might it be
14 appropriate when you get the financing to
15 advise the Board that you have received the
16 financing rather than wait until December or
17 July of '14?

18 Does that make sense to you?

19 MR. CLANCY: Justice, that's part
20 of the condition that they've placed on the
21 CON permit, that we have to give to IDPH proof
22 of the loan as soon as we learn that we have
23 the loan.

24 CHAIRPERSON OLSON: If I understand

1 correctly -- help me out, Frank -- if we
2 revoke the permit today by not --

3 MR. URSO: If you deny the permit
4 renewal, that is a revocation of the permit.

5 CHAIRPERSON OLSON: Does everybody
6 understand that?

7 MEMBER PENN: I'm sorry. Say it
8 again.

9 MR. URSO: If you do not approve
10 this renewal, if you deny this renewal, that
11 is in effect a revocation of the permit. It's
12 a revocation of the permit if you don't
13 approve the renewal.

14 MEMBER SEWELL: Madam Chairman?

15 CHAIRPERSON OLSON: Mr. Sewell?

16 MEMBER SEWELL: Has there always
17 been a two-year construction cycle on this
18 consistently or is this a different cycle?

19 It sounds like to get financing by
20 December, then it looks like you need calendar
21 '14 and '15 to get to that January '16
22 completion.

23 Has it always been this 24-month cycle?

24 MR. HIATT: Yes, sir.

1 MR. CLANCY: Well, with a little
2 bit of a difference.

3 We originally had a very aggressive
4 construction date because the CMS regulation
5 requires all nursing homes to be fully
6 sprinklered, actually, by now. So we had
7 tried to have the replacement facility
8 complete by that time.

9 Since it didn't happen, in talking to
10 the construction managers, they say a safe
11 date is two years from the start of the
12 construction. So we picked the two dates from
13 the end of the condition on the financing.

14 Hopefully, we will start before then,
15 before the winter, so that we can get a head
16 start on that.

17 CHAIRPERSON OLSON: Mr. Penn?

18 MEMBER PENN: I had the same
19 question.

20 I have 15 months down for the start to
21 finish on the original application. I had a
22 question about time of the construction.
23 You've answered it.

24 MR. CLANCY: Thank you.

1 CHAIRPERSON OLSON: Doctor?

2 MEMBER BURDEN: I just reminded
3 myself that we have had these issues with USDA
4 before.

5 Again, do I understand financing is
6 still thought to be in place, approval is
7 thought to be in place, but it isn't as of
8 this moment with your presence here today?
9 Correct?

10 MR. CLANCY: That's right.

11 The stage where it's at right now, they
12 have to finish getting it out of the State and
13 send it to DC. Dc then puts together
14 conditions for the loan and sends it back to
15 the applicant for signature. It's basically
16 very standard.

17 At that point or thereafter, they then
18 fund the loan.

19 MEMBER BURDEN: I'd ask Mr. Urso
20 for clarification. We've been on this turf,
21 it seems to me, several times before, and
22 we've always struggled around what's the
23 proper course.

24 One, is it approval today without

1 financing in place only in the hope that it's
2 going to occur?

3 Is this within the purview of our Board
4 rules?

5 Can we approve this ongoing problem with
6 lack of financing? That means without
7 definite evidence of approval, can we approve?

8 CHAIRPERSON OLSON: My
9 understanding is we have several options here.
10 We can grant the renewal as requested, we can
11 grant a permit renewal to December 31st so
12 that we know that the financing is in place,
13 or we could deny the permit renewal.

14 So there are three different options
15 that the Board has in this situation.

16 MEMBER BURDEN: So what you've said
17 is -- if I understand what you just said -- I
18 asked Mr. Urso's approval, but I expect that
19 you have said what he would say; namely, we
20 can approve it today -- it's one of the
21 options -- even though financing, again, is
22 not secured; correct?

23 MR. URSO: You can approve it, you
24 can modify the dates, or you can deny it.

1 Those are the options at this point in time.

2 If you want -- because they have not
3 received financing and this is going on for
4 such a long period of time, the Board has the
5 right to say, "We're not going to extend it as
6 far as you want. We want to check in sooner
7 so we can determine if you have the financing
8 in by that time."

9 So you can modify the date or you can
10 grant it as they request it or you can deny
11 it.

12 I thought I heard my name when you were
13 talking.

14 MEMBER PENN: I would ask that we
15 modify these rules so the financing is in
16 place before they come to this table so we
17 know where they're at in this situation about
18 the possibility of financing being available
19 or being denied, if Mike is taking a look at
20 the application.

21 Is there any progress with that rule
22 change that we have that the applicants would
23 have the financing in place before they come
24 to the Board?

1 CHAIRPERSON OLSON: Can you not get
2 your financing without a CON approval?

3 MR. CLANCY: That has generally
4 been my experience and everyone I knows
5 experience. We can get, you know, preliminary
6 approval before we get the CON, but no one is
7 going to give final approval without that CON.

8 CHAIRPERSON OLSON: Do you want to
9 weigh in on that, Mr. Constantino?

10 MR. CONSTANTINO: Yeah.

11 In the past the State Board Staff has
12 approved or signed off on these applications
13 that were intended to be financed by HUD or
14 the USDA even though they did not have
15 financing in place.

16 Well, it turns out that they couldn't
17 get it after an extended period of time. They
18 had told us they needed a CON permit to go
19 forward with their applications to HUD or the
20 USDA.

21 So that's how we were operating until we
22 ran into issues with other long-term care
23 facilities, that they couldn't get the
24 financing.

1 So we're demanding a lot more
2 documentation and a commitment that they do
3 have the financing going forward, to David's
4 question. Even though they are not in the
5 rules yet, we are demanding as additional
6 information a commitment -- a solid
7 commitment, a loan commitment going forward.

8 Unfortunately, for this application the
9 State Board Staff accepted what they told us,
10 and we moved forward with it.

11 MEMBER SEWELL: In the State Agency
12 Report, there's two criteria related to
13 financing where the debt portion is unknown.

14 Do we have what the debt financing terms
15 would be should they get financing, or does
16 that come with getting financing?

17 In other words, can he do the
18 calculations?

19 MR. CONSTANTINO: That comes with
20 the approval from the USDA. We don't know
21 what the terms would be yet.

22 MEMBER SEWELL: I'd personally
23 would be reluctant to approve or disapprove
24 this application until we know what those

1 terms are because you can't assess all of the
2 criteria.

3 CHAIRPERSON OLSON: I'm not sure
4 doing nothing is an option.

5 Can we ask him to come back, defer? No?

6 MEMBER BURDEN: Excuse me.

7 I agree with Mr. Sewell. That's
8 essentially how I feel, and yet we are stuck;
9 correct? There has to be a move one way or
10 the other.

11 We can't just keep talking about this.
12 This has to be changed. We've discussed this
13 ad infinitum. An applicant being present who
14 doesn't have the financing secured, why are
15 they -- do we have to disapprove to have them
16 come back when they get it?

17 I mean, that seems to me to be the
18 logical thing to do here to have solid data
19 that the USDA is going to loan money, the
20 terms of the loan, and go forward.

21 CHAIRPERSON OLSON: The original
22 completion date is today.

23 So they are in violation of the permit
24 if we don't extend that completion date past

1 today; is that correct?

2 MR. CONSTANTINO: That's correct,
3 yes.

4 MEMBER SEWELL: And if we don't do
5 something, then they won't get financing
6 because they are in that loop?

7 CHAIRPERSON OLSON: I guess you
8 call that a rock and a hard place.

9 MR. CONSTANTINO: That's correct.
10 We had recommended that a six-month
11 permit renewal be granted until such time as
12 we knew whether or not they had financing,
13 which would be one of the options that Kathy
14 played out for you.

15 CHAIRPERSON OLSON: Would somebody
16 like to make that motion?

17 MEMBER PENN: It seems we have more
18 hoops to go through with applicants using the
19 USDA. I'm thinking back about critical access
20 hospitals in these rural areas where they go
21 to the USDA for financing.

22 THE REPORTER: Excuse me. I can't
23 hear you.

24 MEMBER PENN: I was just making a

1 comment about the problem, to me as a Board
2 member, as applicants come forward with intent
3 to get loans from USDA.

4 My experience with that, it goes back to
5 critical access hospitals in these rural
6 areas, that they always seem to have these
7 stumbling blocks which cause these delays.

8 Then we're put in this position of
9 either approving or denying, approving a
10 situation that I'm personally not comfortable
11 with or denying the application where they
12 would have to come back and reapply. It
13 always seems to be centered around this USDA
14 loan application.

15 That's why I was hoping the finances
16 could be in place before you come to this
17 table so we can make the best decision for
18 you, the clients, and the people you serve.

19 CHAIRPERSON OLSON: I'm going to
20 try to clarify here because I think I'm a bit
21 confused.

22 One of the motions that we could
23 potentially make -- this is the question -- is
24 that we would not do anything with the

1 completion date, but we would extend the
2 permit until December 31st to give them a
3 chance to have their financing in place; is
4 that correct?

5 MR. URSO: But that would extend
6 the completion date.

7 CHAIRPERSON OLSON: Extend the
8 completion date to what?

9 MR. URSO: You can do it to the
10 same date.

11 CHAIRPERSON OLSON: So then if they
12 came back -- if we extended the completion
13 date also to December 31st, which we know is
14 not a reality, they could come back on
15 December 31st with their financing in place
16 and request to move the completion date to
17 when they think they could get it done?

18 MR. CONSTANTINO: That's correct.

19 CHAIRPERSON OLSON: So what in
20 effect we're doing is not allowing that
21 completion date to go all the way to 2016 but
22 really saying, "You need to come back by
23 December 31st with your financing, and then
24 we'll talk about the completion date"?

1 MR. CONSTANTINO: That's correct.

2 MR. CLANCY: Madam Chair, may I
3 comment?

4 CHAIRPERSON OLSON: Yes, please.

5 MR. CLANCY: We have a hard
6 date out there. There's a hard date of
7 December 31st of this year, at which time if
8 we don't have the financing, we would have to
9 come before you again. At that point you
10 could deny that request.

11 The reality is if we don't have
12 financing by that point, the viability of the
13 project is not very good.

14 What we'd ask is that you extend it for
15 the two years that we're asking because then
16 it's another request. It's another trip to
17 the Board. It's more additional money to the
18 facility. You already have a date out there
19 that's pretty hard, at which you could then
20 deny this from going forward.

21 If we do get the financing and get the
22 proof to IDPH, we'll go forward and won't have
23 to come before you again and spend the
24 additional money to ask for the extension of

1 project completion date.

2 So that's why we're asking -- and we
3 think it's reasonable to ask -- to have the
4 two years from the end of the condition on the
5 permit for the financing.

6 CHAIRPERSON OLSON: To clarify his
7 comment, if we would approve it to the
8 requested date of 2016 and they don't have the
9 financing by December 31st of this year, it's
10 a moot point anyway.

11 MR. CONSTANTINO: Well, they would
12 still have a valid permit.

13 CHAIRPERSON OLSON: Until 2016.

14 MR. CONSTANTINO: Yes.

15 MS. KENDRICK: They don't have
16 their financing. That's the condition of the
17 permit.

18 The condition on the permit is they have
19 to get financing by December 31st. If they
20 don't get financing -- and that was the terms
21 of their permit -- they would invalidate the
22 permit.

23 MEMBER SEWELL: If they do get
24 financing, we don't know what the

1 reasonableness of the financing arrangements
2 are or the terms of that financing without a
3 review.

4 CHAIRPERSON OLSON: That's a good
5 point.

6 Would somebody like to make a stab at a
7 motion here?

8 MEMBER BURDEN: Just one thing:
9 Do I understand that one of your objections is
10 that you were fearful of another fee to
11 present your hopeful application when you have
12 financing?

13 Is that fee a stumbling block?

14 You mentioned that you would not like to
15 have to come back and pay another fee to have
16 us assured that we know you have the
17 financing, the permit, the financing terms,
18 which are, crucial, I think? I agree with
19 Mr. Sewell. Is that correct?

20 My question is: Is the fee the
21 stumbling block for you to return with
22 financing in hand and then we would understand
23 the terms? Am I wrong?

24 CHAIRPERSON OLSON: Just so we're

1 clear, I'm told that's a \$2,500 fee.

2 MEMBER BURDEN: Can we waive the
3 fee in this particular circumstance?

4 MR. CONSTANTINO: It's \$500.

5 CHAIRPERSON OLSON: Oh, \$500.

6 MEMBER BURDEN: How much?

7 MR. CONSTANTINO: \$500.

8 CHAIRPERSON OLSON: I misspoke.

9 MR. CLANCY: Dr. Burden, to answer
10 your question, it's not a stumbling block but
11 it is a concern. It's a financial concern.

12 MEMBER BURDEN: I understand.

13 But you understand our situation as you
14 heard articulated. We're asked to do
15 something that we don't really -- we don't
16 have all the details that we need to have a
17 firm vote on what you're requesting. That's
18 what we're going through.

19 MR. CLANCY: And you want
20 information in regard to the terms of the
21 loan.

22 MEMBER BURDEN: The terms of the
23 loan, sure.

24 MR. CLANCY: We can supply that to

1 IDPH, and they can make that available to you.
2 It would be a public document at that point.

3 MEMBER BURDEN: We should have it
4 back before we -- in the past we've requested
5 what I just stated, and it's been complied
6 with, and then we can vote strongly for what
7 you request of us.

8 CHAIRPERSON OLSON: Just to move
9 this along, I'm going to propose a motion
10 that --

11 MEMBER PENN: Can I ask one last
12 question?

13 CHAIRPERSON OLSON: Yes, please.

14 MEMBER PENN: You had made a
15 comment about nursing homes are required to
16 have a sprinkling system in place by now.
17 You're going to tear down one and then build a
18 new one.

19 Your existing facility, has it all been
20 sprinkled and meets the State codes?

21 MR. CLANCY: It's not fully
22 sprinkled. It's partly sprinkled.

23 CMS has put out some proposed rules in
24 relation to a facility that is not sprinkled

1 and how we're going to address that issue.

2 They have said in their proposed rules
3 that one of the conditions for agreeing to
4 waive the requirement being met as of August
5 of this year would be if the plan to address a
6 fully sprinklered facility was to replace it
7 because it recognizes that it's not usually
8 very viable and it's very expensive to fully
9 sprinkler a building. If you're going to
10 replace it, they recognize that it's an
11 acceptable plan to fully sprinkler the
12 building.

13 CHAIRPERSON OLSON: Are you allowed
14 admissions at this point, new admissions?

15 MR. CLANCY: Certainly, yes.

16 CHAIRPERSON OLSON: I'm going to
17 make a motion that you can choose to approve
18 or not approve.

19 I'm going to move that we extend the
20 completion date to December 31st of 2013, at
21 which point the applicant will come back to
22 the Board with the financing in place and the
23 terms of the financing, and then we can
24 discuss again moving that completion date to

1 2016. That's a motion.

2 MEMBER BURDEN: So moved.

3 MEMBER GREIMAN: Second.

4 CHAIRPERSON OLSON: I have a motion
5 and a second.

6 Does everybody understand the motion?

7 Can I have a roll call vote, please?

8 MR. ROATE: Yes, Madam Chairwoman.

9 Motion made by Dr. Burden, seconded by
10 Justice Greiman.

11 Mr. Bradley?

12 MEMBER BRADLEY: Yes.

13 MR. ROATE: Dr. Burden.

14 MEMBER BURDEN: Yes.

15 MR. ROATE: Senator Demuzio.

16 MEMBER DEMUZIO: Yes.

17 MR. ROATE: Justice Greiman.

18 MEMBER GREIMAN: Yes.

19 MR. ROATE: Ms. Olson.

20 CHAIRPERSON OLSON: Yes.

21 MR. ROATE: Mr. Penn.

22 MEMBER PENN: Yes.

23 MR. ROATE: Mr. Sewell.

24 MEMBER SEWELL: Yes.

11-013 - BEL-WOOD NURSING HOME

59

1 MR. ROATE: Seven votes in the
2 affirmative.

3 CHAIRPERSON OLSON: Thank you. We
4 will see you, then, in January.

5 MR. CLANCY: Thank you.

6 CHAIRPERSON OLSON: Our next up on
7 the docket is Item 11-013, Bel-Wood Nursing
8 Home, Peoria.

9 Would those folks please come to the
10 table.

11 I will allow Mr. Constantino to do the
12 SAR report first.

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

15 On May 10, 2011, the permit holder was
16 approved for the discontinuation of a 300-bed
17 long-term care facility in Peoria, Illinois,
18 and the establishment of a 214-bed facility
19 located in West Peoria, Illinois.

20 The approved permit amount is
21 approximately \$49,000,000. The permit holder
22 is asking to extend the completion date from
23 September 30, 2013, to March 31, 2014, or
24 approximately six months. The reason for the

11-013 - BEL-WOOD NURSING HOME

60

1 permit renewal is the permit holder needs to
2 complete the audit.

3 Thank You, Madam Chairwoman.

4 CHAIRPERSON OLSON: Thank you.

5 Would the gentlemen at the table please
6 state your name, spell it for the court
7 reporter, and she will swear you in.

8 MR. KNIERY: My name is John
9 Kniery, K-n-i-e-r-y.

10 MR. NIEUKIRK: Matt Nieukirk,
11 N-i-e-u-k-i-r-k.

12 (The witnesses were thereupon
13 duly sworn.)

14 CHAIRPERSON OLSON: And if you have
15 comments for the Board, please.

16 MR. KNIERY: My only comment is we
17 have financing. We'd be happy to answer any
18 questions you may have.

19 CHAIRPERSON OLSON: Thank you.

20 Does the Board have any questions?

21 Then I'll entertain a motion.

22 MEMBER BRADLEY: So move.

23 MEMBER DEMUZIO: Second.

24 MR. ROATE: Motion made by

11-013 - BEL-WOOD NURSING HOME

61

1 Mr. Bradley, seconded by Senator Demuzio.

2 Mr. Bradley?

3 MEMBER BRADLEY: Yes.

4 MR. ROATE: Dr. Burden.

5 MEMBER BURDEN: Yes.

6 MR. ROATE: Senator Demuzio.

7 MEMBER DEMUZIO: Yes.

8 MR. ROATE: Justice Greiman.

9 MEMBER GREIMAN: Yes.

10 MR. ROATE: Ms. Olson.

11 CHAIRPERSON OLSON: Yes.

12 MR. ROATE: Mr. Penn.

13 MEMBER PENN: Yes.

14 MR. ROATE: Mr. Sewell.

15 MEMBER SEWELL: Yes.

16 MR. ROATE: Seven votes in the
17 affirmative.

18 CHAIRPERSON OLSON: Just for the
19 record, I'm going to say that the motion was
20 to approve the permit renewal request for
21 Bel-Wood Nursing Home.

22 MR. KNIERY: Thank you.

23 CHAIRPERSON OLSON: The next item
24 on the docket is Extension Requests, and we

**017-13 - CENTRAL DUPAGE PROCURE
CANCER TREATMENT CENTER**

62

1 have none.

2 The next item is the Exemption Requests,
3 Item 017-13, Central DuPage ProCure Cancer
4 Treatment Center.

5 The State Agency Report,
6 Mr. Constantino?

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

9 In July 2008 the Board approved a proton
10 therapy system in Warrenville, Illinois, at a
11 cost of approximately \$117 million. Cadence
12 Health proposes to purchase all of ProCure
13 Treatment Center's ownership interest in
14 Chicago ProCure Management, LLC, which
15 currently owns and operates the Proton Center.

16 In addition to ProCure's ownership
17 interest in the Proton Therapy Center, Cadence
18 Health is also purchasing financial claims
19 that ProCure has against the Proton Therapy
20 Center.

21 The estimated cost of the transaction is
22 approximately \$25 million; there was no
23 opposition; and no public hearing was
24 requested.

**017-13 - CENTRAL DUPAGE PROCURE
CANCER TREATMENT CENTER**

63

1 CHAIRPERSON OLSON: Thank you,
2 Mr. Constantino.

3 Would the individuals at the table
4 please identify themselves and be sworn in?

5 MR. AXEL: Jack Axel, Axel &
6 Associates.

7 MR. VIVODA: Mike Vivoda, President
8 and CEO of Cadence Health.

9 Vivoda, Vi-v-o-d-a.

10 MS. SKINNER: Honey Skinner with
11 Sidley, S-k-i-n-n-e-r.

12 MR. HARTSELL: Bill Hartsell,
13 H-a-r-t-s-e-l-l. I'm a physician with
14 Radiology Oncology Consultants and Medical
15 Director of the CDH Proton Center.

16 MR. CHANDLER: I'm Chris Chandler,
17 C-h-a-n-d-l-e-r. I'm President of the ProCure
18 CDH Proton Center.

19 (The witnesses were thereupon
20 duly sworn.)

21 CHAIRPERSON OLSON: Comments for
22 the Board?

23 MR. VIVODA: Good morning. I'm
24 Mike Vivoda, President and CEO of Cadence

**017-13 - CENTRAL DUPAGE PROCURE
CANCER TREATMENT CENTER**

64

1 South. Thank you for considering the
2 Certificate of Exemption application related
3 to Cadence Health's purchase of the interest
4 that ProCure Treatment Centers has in the
5 Warrenville Proton Therapy Center.

6 As you just heard, this Board approved
7 the construction of this center about five
8 years ago. We have been treating patients for
9 almost 36 months now. It is one of nine such
10 centers in the nation, the only one in
11 Illinois, and offers a unique form of
12 radiation therapy that's very effective for
13 select tumor types.

14 If you approve the proposed transaction
15 today, it will result in Cadence Health simply
16 increasing its ownership interest from about
17 12 percent to 81.25 percent.

18 As you also heard, the total cost of
19 this transaction is \$25 million. We are not
20 in need of financing. We will be paying out
21 of cash investments that are available today.

22 The rest of the team here is available
23 to answer questions, and I'll pause for any
24 comments.

**017-13 - CENTRAL DUPAGE PROCURE
CANCER TREATMENT CENTER**

65

1 CHAIRPERSON OLSON: Thank you.

2 Questions from the Board?

3 Dr. Burden?

4 MEMBER BURDEN: I'm one of the few
5 that was here in '08 with a very contentious
6 situation. I voted strongly for the
7 university. Guess what? They didn't have any
8 dough. Luke had the money.

9 So now we sit, and I hope that all the
10 changes that have occurred -- Cadence is
11 formed. Delnor is still in the group. I'm
12 only interested -- I think it's a wonderful
13 move you're making. I agree with what you
14 have in mind.

15 My query is as a physician. The unit in
16 and of itself, has it been utilized to its
17 completion?

18 We have a radiologist here. I
19 personally as a practicing neurologist have a
20 great deal of skepticism other than the fact
21 that it seems it's allowing for a better
22 reimbursement rate.

23 This is personal, and I'm not attempting
24 to answer my own question, but I'm wondering

017-13 - CENTRAL DUPAGE PROCURE
CANCER TREATMENT CENTER

66

1 has this been utilized to the degree that was
2 anticipated?

3 We listened to a lot of conversations
4 from experts, Indiana, Bloomington, and other
5 places regarding this facility being utilized
6 extensively. I'm interested in hearing from
7 the physician in here who can help me.

8 How busy has it been?

9 MR. VIVODA: I'm going to pass the
10 microphone to Dr. Hartsell, but I will say
11 since the time that the Board approved this,
12 there are more and more tumor sites that are
13 applicable for proton therapy.

14 I'll let Dr. Hartsell elaborate.

15 DR. HARTSELL: Thanks. Good to see
16 you again, Dr. Burden.

17 MEMBER BURDEN: I remember you.

18 DR. HARTSELL: The answer is yes.

19 When we started the facility, we
20 anticipated we'd be treating certain tumor
21 types. Children, that was one of the main
22 goals was to be able to treat children.

23 About 15 percent of the patients we've
24 treated have been children. While most of

**017-13 - CENTRAL DUPAGE PROCURE
CANCER TREATMENT CENTER**

67

1 those are from Illinois, there are some from
2 around the rest of the United States and
3 internationally as well.

4 The second group of patients whom we
5 treat are those who have had prior treatment,
6 radiation therapy, and can't be treated again
7 with conventional radiation therapy, and
8 that's been somewhere between 10 and 15
9 percent of our patients.

10 At the time that we initially had
11 talked, we were thinking more about brain
12 tumors and prostate cancer, the other two that
13 were most commonly treated. The number of
14 patients we treat for prostate cancer has gone
15 down. The number of patients with brain
16 tumors has been constant.

17 We're now treating tumor sites like
18 pancreas, lung cancer, head and neck cancers,
19 and more recently left-sided breast cancer.
20 You may have seen recently that there's a
21 higher risk of heart problems for women who
22 get radiation therapy for left-sided breast
23 cancer. One of the benefits is that protons
24 avoid the heart.

**017-13 - CENTRAL DUPAGE PROCURE
CANCER TREATMENT CENTER**

68

1 In terms of the utilization, we are
2 treating a 14 1/2-hour day. So basically, we
3 treat two shifts; and in terms of the
4 capacity, we're at about 70 percent capacity
5 with individual rooms. There are some of the
6 treatment rooms that are close to 100 percent
7 capacity.

8 We are on the same ramp-up time schedule
9 as the other centers, like MD Anderson, the
10 University of Pennsylvania, the University of
11 Florida. They were treating about the same
12 number of patients at this point in their
13 existence as well.

14 MEMBER BURDEN: Thank you. I
15 appreciate that, particularly your comment
16 about breast radiation. I've had more than a
17 few -- I'm older. My friends are older --
18 women who have had radiation and now run into
19 coronary artery disease.

20 The thoughtful cardiac surgeons are
21 reluctant to practice on somebody who may have
22 heart damage secondary to radiation. So
23 that's interesting. Thank you. Thank you
24 much.

**017-13 - CENTRAL DUPAGE PROCURE
CANCER TREATMENT CENTER**

69

1 It has nothing to do, really, with the
2 application. It helped me with the overall
3 picture of what proton therapy has added to
4 the treatment panorama here in the state of
5 Illinois. Thank you.

6 CHAIRPERSON OLSON: Any other
7 questions?

8 Mr. Penn?

9 MEMBER PENN: I did have a
10 question. I was also on the Board when we
11 made the approval, and it has no bearing on my
12 intent to vote.

13 What is the percentage of your charity
14 care at this facility?

15 MR. VIVODA: The charity care
16 policy of the center is identical to Cadence
17 Health.

18 Do we know the exact numbers, Chris?

19 MR. CHANDLER: Chris Chandler.

20 I don't have the exact percentage. I'm
21 happy to find it for you, but we are treating
22 charity care cases. We have adopted, as Mike
23 has said, the Cadence policy, but at any given
24 time have a number of patients on charity care

**017-13 - CENTRAL DUPAGE PROCURE
CANCER TREATMENT CENTER**

70

1 policy, including a lot of our children as
2 well.

3 MEMBER PENN: I would like to find
4 out what that is.

5 As I recall, you were the second
6 application, and the university received the
7 first site approval, and we had a lot of
8 dialogue and experts that came in from Harvard
9 and other places.

10 I was glad that we voted for this
11 facility, but with now 70 percent occupancy
12 three years online, I'm curious about your
13 charity care.

14 MR. VIVODA: Let me add a
15 definitive comment that may help to answer at
16 least partially.

17 15 percent of the patients being treated
18 are pediatric patients. The great majority
19 are pediatric brain tumor patients that are in
20 alignment with our relationship with Lurie
21 Children's Hospital.

22 Their payer mix replicates our payer
23 mix. 43 percent are on Medicaid, and about 15
24 percent are actually uninsured. That's an

**017-13 - CENTRAL DUPAGE PROCURE
CANCER TREATMENT CENTER**

71

1 approximate, but we'd be happy, Mr. Penn, to
2 get you the specific numbers.

3 MEMBER PENN: Thank you.

4 CHAIRPERSON OLSON: May I have a
5 motion to approve this project?

6 MEMBER DEMUZIO: Motion.

7 MEMBER BURDEN: Second.

8 CHAIRPERSON OLSON: I have a motion
9 and a second to approve Project 017-13,
10 Central DuPage ProCure Cancer Treatment Center
11 for an ownership exemption.

12 May I have a roll call vote?

13 MR. ROATE: Motion made by Senator
14 Demuzio, seconded by Dr. Burden.

15 Mr. Bradley.

16 MEMBER BRADLEY: Yes.

17 MR. ROATE: Dr. Burden.

18 MEMBER BURDEN: Yes.

19 MR. ROATE: Senator Demuzio.

20 MEMBER DEMUZIO: Yes.

21 MR. ROATE: Justice Greiman.

22 MEMBER GREIMAN: Yes.

23 MR. ROATE: Ms. Olson.

24 CHAIRPERSON OLSON: Yes.

018-13 - DECATUR HEALTHCARE, LLC

72

1 MR. ROATE: Mr. Penn.

2 MEMBER PENN: Yes.

3 MR. ROATE: Mr. Sewell.

4 MEMBER SEWELL: Yes.

5 MR. ROATE: Seven votes in the
6 affirmative.

7 CHAIRPERSON OLSON: Thank you.

8 Let's move on to 018-13, Decatur
9 Healthcare, LLC. This is also for a change of
10 ownership exemption.

11 Are the representatives here from
12 Decatur? There are no representatives here
13 from Decatur Healthcare, LLC?

14 Staff report?

15 MR. CONSTANTINO: Thank you, Madam
16 Chairwoman.

17 The permit holders are proposing the
18 purchase of 100 percent ownership interest of
19 Decatur Healthcare, LLC, a multispecialty ASTC
20 in Decatur, Illinois. The cost of the project
21 is \$875,000. There was no opposition and no
22 public hearing was requested.

23 Thank you.

24 CHAIRPERSON OLSON: I guess any

1 questions from the Board will be directed to
2 Mr. Constantino or the empty chairs.

3 Any questions? Yes?

4 MR. URSO: So they met all the
5 requirements for this?

6 MR. CONSTANTINO: Oh, yes, they
7 sure have.

8 They were contacted, and they were told
9 that we had a meeting August 13, 2013. This
10 is a Tom Pliura facility.

11 CHAIRPERSON OLSON: May I have
12 a motion to accept the exemption request for
13 Decatur Healthcare, LLC?

14 MEMBER DEMUZIO: Yes, I make a
15 motion.

16 MEMBER SEWELL: Second.

17 CHAIRPERSON OLSON: I have a motion
18 and second.

19 George, a roll call vote?

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

22 Mr. Bradley.

23 MEMBER BRADLEY: Yes.

24 MR. ROATE: Dr. Burden.

1 MEMBER BURDEN: Yes.

2 MR. ROATE: Senator Demuzio.

3 MEMBER DEMUZIO: Yes.

4 MR. ROATE: Justice Greiman.

5 MEMBER GREIMAN: Present.

6 Present because I would like to see them
7 put a little energy in it themselves.

8 MR. ROATE: Ms. Olson.

9 CHAIRPERSON OLSON: Yes.

10 MR. ROATE: Mr. Penn.

11 MEMBER PENN: Present.

12 MR. ROATE: Mr. Sewell.

13 MR. SEWELL: Yes.

14 MR. ROATE: That's five votes in
15 the affirmative, two votes present.

16 CHAIRPERSON OLSON: Motion passes.

17 MEMBER SEWELL: Can we stipulate
18 that they didn't vote yes to encourage
19 applicants to not show up?

20 CHAIRPERSON OLSON: Let the record
21 reflect that the yes vote does not encourage
22 applicants not to show up.

23 Good point. Thank you, Mr. Sewell.

24 Okay. Item 11-095, Palos Hills Surgery

11-095 - PALOS HILLS SURGERY CENTER

75

1 Center, and we do have representatives. That's
2 awesome.

3 Mr. Constantino, Staff Report, please?

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

6 On February 28, 2012, the applicant was
7 approved to establish a limited specialty ASTC
8 in Palos Hills, Illinois, that will perform
9 orthopedics and plastic surgery specialties.

10 The approved permit amount is
11 \$2.4 million. The permit holders are
12 proposing to increase the cost of the permit
13 from \$2.4 million to \$2.6 million or
14 approximately \$160,000. There was no
15 opposition and no public hearing was
16 requested.

17 Thank you, Madam Chairwoman.

18 CHAIRPERSON OLSON: Would the
19 presenters' table introduce yourselves?

20 MR. HUNT: Tom Hunt, H-u-n-t,
21 administrator.

22 MR. DUNNE: Matthew Dunne of Murer
23 Consultants. Dunne is D-u-n-n-e. Murer is
24 M-u-r-e-r.

11-095 - PALOS HILLS SURGERY CENTER

76

1 CHAIRPERSON OLSON: Please be sworn
2 in.

3 (The witnesses were thereupon
4 duly sworn.)

5 CHAIRPERSON OLSON: Comments for
6 the Board, please?

7 MR. DUNNE: I think it would be
8 helpful to start by providing some context and
9 background as to this alteration request.

10 Palos Hills Surgery Center received CON
11 approval in February 2012 to proceed with the
12 modernization of existing space within its
13 medical office building to establish two ORs
14 to treat patients requiring specialized
15 surgery for the hand and upper extremities.

16 In this regard, we would like to request
17 approval of an additional \$160,000 to complete
18 this project.

19 In June of this year, we advised the
20 Board that as much as \$350,000 would be
21 shifted from equipment to construction costs
22 but that the overall cost of the project would
23 not increase.

24 It was anticipated that the project

1 would be able to generate the necessary
2 savings in the cost of equipment purchase.
3 Furthermore, we did not wish to exceed the
4 originally approved permit amount unless
5 absolutely necessary.

6 Unfortunately, this alteration request
7 was necessary because it was not possible to
8 generate the projected level of savings in
9 equipment costs we had anticipated. In this
10 regard, we are asking for an additional
11 \$160,000 in order to complete the project.

12 It should be noted that this will be an
13 increase of roughly 6.5 percent of the total
14 project cost, which is within the necessary
15 threshold for Board approval.

16 This request is being made as a result
17 of unforeseen construction cost increases,
18 which were a result of the field conditions we
19 discovered as we proceeded with the project
20 that were beyond our control and
21 unanticipated.

22 I and Mr. Tom Hunt of Palos Hills
23 Surgery Center are prepared to answer any
24 questions you may have.

1

2

CHAIRPERSON OLSON: Questions from
the Board?

3

4

Mr. Penn?

5

6

MEMBER PENN: What were those
construction costs?

7

8

9

10

11

MR. HUNT: The construction costs
are some unforeseen issues that we ran into;
namely, we had to do structural steel bracing
for the operating room lights and for the
ventilation unit on the roof.

12

13

14

15

16

We ran into some issues with some
existing ventilation that was right outside
one of the ORs that had to be moved and
shifted to an outside wall, which created
quite an expense.

17

18

19

20

We also had an electrical room where all
the electrical components had to be shifted
and moved. So that this is another expense
that we ran into.

21

22

23

MEMBER PENN: And the architect,
the engineer, nobody offered to pick up those
costs?

24

MR. HUNT: When we obtained our

1 CON, we had an architect, but we changed
2 architects during the project. Once we
3 changed architects, we did foresee some issues
4 because this is an older building, but we did
5 not foresee some of the issues that we ran
6 into later.

7 In some respects -- we switched
8 architects through the project -- we were able
9 to see some of the additional expenses we were
10 going to have. We tried to shift some of the
11 costs from our equipment budget, but we
12 weren't able to completely realize the savings
13 that we thought we could with the equipment.

14 CHAIRPERSON OLSON: Dr. Burden?

15 MEMBER BURDEN: My query has little
16 to do with, really, why you're here today to
17 get an extra few dollars to complete, but I go
18 back to January 12th and then subsequently
19 February 12th.

20 I'm curious about the State standard met
21 regarding utilization. This has been apparent
22 to me as a physician. We're seeing more and
23 more applications for ambulatory surgical
24 treatment centers. Yet I'm looking at an

1 issue that we overlooked or we voted for this
2 application even though we were aware there
3 was a certain number in the community working.

4 So I'm curious. How active has your
5 unit been since this application?

6 Do you intend to demonstrate to us that
7 your activity will meet the standard that we
8 hope you do?

9 Has there been any change in your
10 attitude regarding that as you go forward with
11 the building of this unit?

12 MR. HUNT: No, there is no change
13 whatsoever. We're going to go forward and be
14 involved in the community and provide the
15 services that we initially presented to the
16 Board.

17 MEMBER BURDEN: Well, I'd
18 appreciate if you'd be more circumspect
19 regarding this, not yours particularly. You
20 have the application approved. We anticipate
21 you're going forward.

22 I go back and I review my notes
23 regarding the number of times we approve
24 things like this type of building, and the

11-095 - PALOS HILLS SURGERY CENTER

81

1 units in the area are not meeting the
2 standards. We're looking forward to seeing
3 follow-up, I think, in terms of seeing the
4 standards being met that are in place. That's
5 all.

6 MR. HUNT: Very good.

7 CHAIRPERSON OLSON: Other
8 questions?

9 I have a question. Your project is 90
10 percent complete; is that correct?

11 MR. HUNT: Yes, it is.

12 CHAIRPERSON OLSON: How are you
13 going to get the \$160,000 that you cut out of
14 the equipment budget? Are you just buying
15 less equipment?

16 MR. HUNT: We're actually using
17 very aggressive purchasing. We're using GPL
18 contracts. We've aggressively decreased our
19 equipment budget, but the additional \$160,000
20 will be funded by cash.

21 CHAIRPERSON OLSON: Thank you.

22 Other questions from the Board?

23 May I have a motion to approve Project
24 11-095, Palos Hills Surgery Center?

11-095 - PALOS HILLS SURGERY CENTER

82

1 MEMBER GREIMAN: So moved.
2 MEMBER PENN: Second.
3 CHAIRPERSON OLSON: Roll call vote,
4 please?
5 MR. ROATE: Motion made by Justice
6 Greiman, seconded by Mr. Penn.
7 Mr. Bradley.
8 MEMBER BRADLEY: Yes.
9 MR. ROATE: Dr. Burden.
10 MEMBER BURDEN: Yes.
11 MR. ROATE: Senator Demuzio.
12 MEMBER DEMUZIO: Yes.
13 MR. ROATE: Justice Greiman.
14 MEMBER GREIMAN: Yes.
15 MR. ROATE: Ms. Olson.
16 CHAIRPERSON OLSON: Yes.
17 MR. ROATE: Mr. Penn.
18 MEMBER PENN: Yes.
19 MR. ROATE: Mr. Sewell.
20 MEMBER SEWELL: Present.
21 MR. ROATE: That's six votes in the
22 affirmative, one vote present.
23 CHAIRMAN OLSON: Motion passes.
24 I have 11:20. We're going to take a

1 ten-minute break. We will resume at 11:30.

2 Thank you.

3 (Whereupon, a recess was had
4 at 11:20 a.m., after which
5 the proceedings were resumed
6 at 11:30 a.m. as follows:)

7 CHAIRPERSON OLSON: Declaratory
8 Rulings and Other Business, there's none.

9 Health Care Workers Self-Referral Act,
10 no action.

11 Status Reports on Conditional/Contingent
12 Permits, no action.

13 Applications Subsequent to Initial
14 Review, Item No. 13-020, VHS Westlake
15 Hospital. I see the representatives are at
16 the table. Thank you.

17 Mr. Constantino, the SAR Report?

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

20 The applicants propose to discontinue
21 its Open-Heart Surgery category of service
22 located in Melrose Park, Illinois. There's no
23 cost to this project. The completion date is
24 October 12, 2013.

1 Thank you.

2 CHAIRPERSON OLSON: Thank you,
3 Mr. Constantino.

4 If the individuals at the table would
5 identify themselves and be sworn in, please.

6 MR. FOLEY: Yes. My name is
7 William Foley, F-o-l-e-y, and I am a Senior
8 Vice President of Vanguard Health Systems.
9 I'm joined by Joan Ormsby, O-r-m-s-b-y, who is
10 the interim CEO and Chief Operating Officer at
11 Westlake Hospital and West Suburban Hospitals,
12 and Dr. Robert Chase, C-h-a-s-e, who is Chief
13 Medical Officer at Westlake Hospital and West
14 Suburban Hospital.

15 CHAIRPERSON OLSON: Be sworn in,
16 please.

17 (The witnesses were thereupon
18 duly sworn.)

19 CHAIRPERSON OLSON: Thank you.

20 Comments for the Board?

21 Excuse me just a minute. Frank had one
22 comment he wanted to make.

23 MR. URSO: I just wanted the Board
24 members to be aware that we did have a

1 compliance issue with this facility. It has
2 been completely resolved satisfactorily, and
3 there are no further extenuating circumstances
4 with the compliance issue.

5 MR. FOLEY: First of all, we thank
6 you for the opportunity to appear today before
7 the Board to discuss Westlake Hospital's
8 application to discontinue Open-Heart Surgery
9 category of services.

10 The decision to discontinue open-heart
11 surgery at Westlake was based on a two-year
12 system-wide analysis to determine the best way
13 to offer comprehensive cardiovascular care to
14 the communities Vanguard serves throughout
15 Chicagoland.

16 This included a review of the
17 cardiovascular services we offer at each of
18 our hospitals. The analysis showed that only
19 ten open-heart surgery cases were performed at
20 Westlake in the year 2012. This averages less
21 than one per month.

22 The low utilization of open-heart
23 surgery services at Westlake reflects the
24 proximity of other open-heart surgery

1 providers as well as the decline of open-heart
2 surgery as other less invasive therapies and
3 procedures are being deployed.

4 As discussed in our application, access
5 to needed open-heart surgery services will not
6 be negatively impacted by eliminating
7 Westlake's open-heart surgery program.

8 West Suburban Hospital, another of our
9 Vanguard hospitals, currently offers
10 open-heart surgery and is located just 4 miles
11 or less than 15 miles away from Westlake.

12 Operating separate open-heart surgery
13 programs at Westlake and West Suburban
14 Hospitals is not only duplicative but limits
15 our ability to maximize the skills and
16 expertise of our physicians and our
17 clinicians.

18 Additionally, 28 open-heart surgery
19 centers are located within 45 minutes of
20 Westlake, which includes a program at West
21 Suburban Hospital.

22 As you are aware, there's no opposition
23 to this project and no public hearing was
24 called.

1 Again, we thank you for the opportunity
2 to appear before the Board today, and we'd
3 like to thank the Agency's administrative
4 staff for their technical assistance
5 throughout the review process. We're happy to
6 answer any questions.

7 CHAIRPERSON OLSON: Thank you.
8 Questions from the Board?
9 Dr. Burden?

10 MEMBER BURDEN: Thank you very
11 much, Madam Chairman.

12 I guess I'm curious to say that my
13 understanding -- I've been retired now for 13
14 years, but I pal around with a couple heart
15 surgeons socially. That number is so low.

16 Obviously, they argue that it should
17 have been discontinued, period, but I'm happy
18 to hear you're making that stand. That
19 doesn't profess for kind of -- they do one a
20 month.

21 I'm just curious why it was brought to
22 your attention that this is -- you're doing
23 the right thing in my judgment as a physician,
24 obviously. You recognize that. Cardiac

1 surgery is a money maker. That's also very
2 obvious.

3 But when you're not doing but one a
4 month and places around the City are really
5 continuing to increase, I wondered: How did
6 it happen that it got so low?

7 When you were here and purchased the
8 institution at the same time as West Suburban,
9 what was the -- I don't recall. I remember
10 you being here when Vanguard purchased those
11 two institutions and there was a nice generous
12 offer.

13 Was the heart surgery program that weak
14 at the time, or did it just occur since you
15 bought the hospital?

16 MR. FOLEY: I do know that in 2011
17 we did 28 open-heart surgeries.

18 MEMBER BURDEN: Yes, that is here
19 in my record, 28.

20 MR. FOLEY: I don't recall what it
21 was when Vanguard acquired the hospital; but
22 when we received CON, you know, for the
23 transfer of ownership to Vanguard from
24 Resurrection 3 years ago, with the CON there

1 was an agreement that we would not reduce
2 services. So that three-year period just
3 recently expired.

4 MEMBER BURDEN: I see.

5 What is the future of Vanguard and your
6 hospital in our community?

7 MR. FOLEY: Vanguard, as I'm sure
8 you know and you've read, you know, is in
9 discussions with Tenet about Tenet acquiring
10 the Vanguard Health System across the country,
11 all 28 hospitals, but, you know, Tenet remains
12 committed to the hospitals in Chicago.

13 We do have a Tenet representative with
14 us, Mr. Corey Davidson.

15 MEMBER BURDEN: No. I'm just
16 curious because obviously I read what you just
17 said.

18 I'm wondering is this going forward as
19 proposed as far as our community is concerned?

20 MR. FOLEY: That commitment
21 remains.

22 MEMBER BURDEN: Thank you.

23 CHAIRPERSON OLSON: Any other
24 questions?

1 MEMBER GREIMAN: This is a little
2 off the subject, but your charity care
3 material, in '09 you had 3,140 folks and in
4 2011, 462. That's incredible. That's an 82
5 percent drop.

6 The interesting thing is that you spent
7 \$855,000 on these 3,000 people and a million
8 on 462 people. Why the drop?

9 MR. FOLEY: Well, let me just say
10 that, first of all, we do have a charity care
11 policy at Vanguard. We don't turn anyone
12 away.

13 MEMBER GREIMAN: It would seem like
14 certainly over 3,000 to 400 in the year, that
15 looks like a change in policy, doesn't it?

16 MR. FOLEY: It's difficult for us
17 to speak to all of those numbers because the
18 prior years really were generated from
19 Resurrection. Those are not our numbers.

20 MEMBER GREIMAN: All right. That
21 gives me some cause for question.

22 CHAIRPERSON OLSON: Mr. Sewell?

23 MEMBER SEWELL: I want to ask Staff
24 a question.

13-020 - VHS WESTLAKE HOSPITAL

91

1 Years ago open-heart surgery there was a
2 standard that everybody ought to be doing at
3 least 200 annually before you allow new ones.

4 Is that still a part of our rules?

5 MR. CONSTANTINO: Yes.

6 MEMBER SEWELL: Okay.

7 CHAIRPERSON OLSON: Seeing no
8 further questions, I would ask for a motion to
9 approve.

10 MEMBER GREIMAN: I have one other
11 one.

12 CHAIRPERSON OLSON: Oh, I'm sorry.
13 I didn't mean to cut you off.

14 MEMBER GREIMAN: It just occurred
15 to me.

16 You provided us with a percentage of
17 charity care, 1.1 percent, and you've taken it
18 against the net revenue of the hospital as
19 opposed to the cost of charity care.

20 What I'm wondering is whether those two
21 are treated the same way. In other words, in
22 hospitals today you charge so much, and then
23 you collect so much and it's less -- it's an
24 amount much less because you have Medicaid and

1 Medicare and insurance and whatnot. So you're
2 asking a \$1,000 and you get \$300. Okay.
3 Fine.

4 In the 1 percent here, though, you have
5 \$89 million as the net revenue, and the amount
6 charity care you put down as \$4 million.

7 The question is whether you're using a
8 different standard. You know what I'm saying?

9 MR. AXEL: Judge, that 1.1 percent
10 is a calculation done by your Staff, and it's
11 based on the cost of charity care.

12 MEMBER GREIMAN: The cost of
13 charity care as opposed to --

14 MR. AXEL: As opposed to charges.

15 MEMBER GREIMAN: The charges of
16 charity care are usually the full amount
17 because you're not going to collect it anyhow;
18 isn't that right?

19 MR. AXEL: That is correct.

20 MEMBER GREIMAN: So one is based on
21 how much we really collect, and the other is
22 based on what we charge and don't collect.
23 Isn't that so?

24 MR. AXEL: One is what it costs to

13-020 - VHS WESTLAKE HOSPITAL

93

1 provide the services that are provided under
2 charity care, the cost. The other is what we
3 want to charge.

4 MEMBER GREIMAN: I see. So that's
5 the net amount. Okay.

6 CHAIRPERSON OLSON: Any further
7 questions?

8 I will entertain a motion to approve
9 Project 13-020, Westlake Hospital to
10 discontinue the open-heart surgery of service.

11 MEMBER SEWELL: So move.

12 MEMBER PENN: Second.

13 MR. ROATE: Motion made by
14 Mr. Sewell, seconded by Mr. Penn.

15 Mr. Bradley.

16 MEMBER BRADLEY: Yes.

17 MR. ROATE: Dr. Burden.

18 MEMBER BURDEN: Yes.

19 MR. ROATE: Senator Demuzio.

20 MEMBER DEMUZIO: Yes.

21 MR. ROATE: Justice Greiman.

22 MEMBER GREIMAN: Yes.

23

24

13-021- FRANCISCAN ST. JAMES SURGERY

94

1 MR. ROATE: Ms. Olson.

2 CHAIRPERSON OLSON: Yes.

3 MR. ROATE: Mr. Penn.

4 MEMBER PENN: Yes.

5 MR. ROATE: Mr. Sewell.

6 MEMBER SEWELL: Yes.

7 MR. ROATE: That's seven votes in
8 the affirmative.

9 CHAIRPERSON OLSON: Motion passes.
10 Thank you.

11 Project 13-021, Franciscan St. James
12 Surgery Center, Chicago Heights.

13 Would those representatives please come
14 to the table?

15 Staff Report, Mr. Constantino?

16 MR. CONSTANTINO: Thank you, Madam
17 Chairwoman.

18 The applicant proposes to discontinue
19 its multispecialty ASTC in Chicago Heights,
20 Illinois. There's no cost to this project,
21 there was no public opposition, and there was
22 no request for a public hearing. The
23 completion date is October 12, 2013.

24 Thank you, Madam Chairwoman.

13-021- FRANCISCAN ST. JAMES SURGERY

95

1 CHAIRPERSON OLSON: Thank you,
2 Mr. Constantino.

3 Will the gentlemen introduce themselves
4 and be sworn in?

5 Does Jack have to be sworn in again?

6 MR. SENESAC: Thomas Senesac,
7 S-e-n-e-s-a-c, Regional Chief Financial
8 Officer, Franciscan Alliance.

9 CHAIRPERSON OLSON: Do you have any
10 comments for the Board?

11 Oh, wait. We have to swear you in.

12 (The witnesses were thereupon
13 duly sworn.)

14 MR. SENESAC: Given the positive
15 Staff Report and no opposition, we don't have
16 any opening comments. Thank you.

17 CHAIRPERSON OLSON: Thank you.

18 Any questions from the Board?

19 Dr. Burden?

20 MEMBER BURDEN: I'm sorry. What is
21 the reason for discontinuation?

22 MR. SENESAC: We have the surgical
23 capacity of our two hospitals, which are
24 located within 3 miles of the facility. We're

1 trying our best to keep our costs down and
2 reduce redundant services whenever possible.
3 We do not believe it will have any impact on
4 the community.

5 MEMBER BURDEN: I'm just curious
6 because government regulations for hospitals
7 cause costs to go up.

8 As a practicing doctor, I certainly
9 recognize the advantage of an ambulatory
10 surgery treatment center, assuming you have
11 adequate standards that are met in the
12 ambulatory surgery treatment center.
13 Hospitals by fiat have standards that are
14 elevated; hence, higher cost.

15 How can you save money by closing an
16 ambulatory surgery treatment center that
17 offers no charity care and has minimal
18 Medicaid? That's according to what I have in
19 front of me. And you're closing the place,
20 and you're going to the hospitals. I mean, to
21 me fiscally -- help me out.

22 MR. SENESAC: Well, by having a
23 third location, you also have the additional
24 fixed costs associated with that location,

1 rent, utilities, and the like.

2 Our analysis was that overall the costs
3 for the entire region -- again, we have three
4 sites located within 3 miles of one another.
5 Our costs would go down.

6 Your question as to charity care, as a
7 facility, it was operated as a department of
8 the hospital. I think we do a very
9 significant amount of charity care at our two
10 hospital locations and will continue to do so.

11 MEMBER BURDEN: I'm not criticizing
12 anything to do with charity care at the
13 hospital.

14 Again, we see this all the time.
15 There's a range of charity care for
16 institutions that's appropriate, and they have
17 to accept it, and ambulatory surgery treatment
18 centers don't. We can't enforce that. We do
19 see it -- but rarely -- that they do charity
20 care or they'll handle doing charity care as
21 Medicaid. Neither one are being done.

22 I appreciate what you're doing. I can't
23 understand the reason behind it. The
24 discontinuation for economic reasons doesn't

1 make any sense. I was in business. I think
2 you have an operation that's busy. Obviously,
3 I think you're overstaffed, but that's not my
4 call. That's your call.

5 But you're closing it, and you're going
6 to send people to the hospital where it's
7 going to cost them more money. Regulations in
8 hospitals cause costs to go up. That's why
9 aspirin pills cost 500 bucks. I'm
10 exaggerating, of course.

11 You know as well as I do when reviewing
12 any number of hospital bills, you see
13 exaggerated fees and exaggerated costs. Those
14 costs could be minimized in an ambulatory
15 surgery center, which is the reason for their
16 existence.

17 So closing it down for the reasons I
18 see -- that's why I wondered -- elude me.

19 MR. AXEL: Dr. Burden, I'd just
20 like to add two things.

21 This is an unusual surgery center.
22 Because it's a surgery center that is 100
23 percent owned by the hospital, there is no
24 physician ownership. So, in fact, as

1 Mr. Senesac mentioned, it operates now as a
2 department of the hospital.

3 Second, there are seven other surgery
4 centers in the area that physicians could take
5 their patients to with the lower cost
6 structure, lower charge structure.

7 MEMBER BURDEN: That's getting
8 closer to an answer.

9 Obviously, we see ambulatory surgery
10 treatment centers that I'm convinced are
11 underutilized for obvious lines. One of the
12 reasons that would make me support it is cost,
13 and I'm here to evaluate cost as well as
14 maldistribution.

15 Hospitals can't reduce costs. They're
16 fixed. They're regulated. The government is
17 behind the cost. Who is kidding who? I
18 worked in one for 40 years, et cetera.

19 Now I understand. That is a reason. I
20 appreciate that.

21 MR. AXEL: I would agree with your
22 point, however.

23 MEMBER BURDEN: It's obvious.
24 There's no way you can argue against what I

13-021- FRANCISCAN ST. JAMES SURGERY

100

1 say. When a hospital owns one, I can
2 appreciate that and the fact that there are
3 plenty in the area. I'm aware of that by
4 looking at what we see.

5 Thank you.

6 CHAIRPERSON OLSON: Further
7 questions from the Board?

8 I have a motion to approve Project
9 13-021, Franciscan St. James Surgery Center
10 for discontinuation of a multispecialty ASTC.

11 Can I have a motion?

12 MEMBER SEWELL: So move.

13 MEMBER DEMUZIO: Second.

14 CHAIRPERSON OLSON: Roll call,
15 please?

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

18 Mr. Bradley.

19 MEMBER BRADLEY: Yes.

20 MR. ROATE: Dr. Burden.

21 MEMBER BURDEN: Yes.

22 MR. ROATE: Senator Demuzio.

23 MEMBER DEMUZIO: Yes.

24 MR. ROATE: Justice Greiman.

13-024 - OSF ST. MARY MEDICAL CENTER

101

1 MEMBER GREIMAN: No.

2 MR. ROATE: Ms. Olson.

3 CHAIRPERSON OLSON: Yes.

4 MR. ROATE: Mr. Penn.

5 MEMBER PENN: No.

6 MR. ROATE: Mr. Sewell.

7 MEMBER SEWELL: Yes.

8 MR. ROATE: That's five votes in
9 the affirmative, two votes in the negative.

10 CHAIRPERSON OLSON: Motion passes.

11 Next up we have Item 13-024, OSF
12 St. Mary Medical Center in Galesburg.

13 Staff Agency Report, please,
14 Mr. Constantino?

15 MR. CONSTANTINO: Thank you, Madam
16 Chairwoman.

17 The applicants propose to discontinue
18 their Cardiac Catheterization category of
19 service located in Galesburg, Illinois. There
20 is no cost to this project; there was no
21 public hearing; and no opposition letters were
22 received.

23 The completion date is June 26, 2013.
24 That was listed in the application. That's

1 been extended until approval of the State
2 Board.

3 Thank You.

4 CHAIRPERSON OLSON: So in effect,
5 the completion date would be today?

6 MR. CONSTANTINO: Yes.

7 CHAIRPERSON OLSON: Questions?

8 Oh, please introduce yourself,
9 gentlemen.

10 MR. HOHULIN: Mark Hohulin,
11 H-o-h-u-l-i-n, Senior Vice President of
12 Decision Support Services, OSF Healthcare
13 System.

14 MR. LIPE: Curt Lipe, L-i-p-e,
15 Chief Financial Officer, OSF St. Mary Medical
16 Center.

17 MR. HENDERSON: Michael Henderson,
18 Corporate Attorney, OSF Healthcare System.

19 CHAIRPERSON OLSON: Do you
20 gentlemen have comments for the Board?

21 MR. HOHULIN: No comments. We're
22 available for questions.

23 CHAIRPERSON OLSON: Thank you.
24 Questions from Board members?

1 Dr. Burden?

2 MEMBER BURDEN: Me again.

3 Where are your patients going to go?

4 It's 55 miles from Peoria. I know quite a bit
5 about the Quad City area, having multiple
6 relatives there. That seems to be an option.

7 But if I'm living in a town which has a
8 university, Knox College, and their people
9 that work there have chest pain, where do they
10 go?

11 CHAIRPERSON OLSON: Can I hold you
12 one second?

13 Did we swear them in?

14 THE REPORTER: No.

15 (The witnesses were thereupon
16 duly sworn.)

17 CHAIRPERSON OLSON: Now if you
18 remember the question, you can answer.

19 MR. LIPE: Currently we are taking
20 a regional approach to cardiac services. We
21 do have a chest pain center at the hospital
22 where we can treat the initial presentation,
23 but we do Life Flight those patients directly
24 in to Peoria for their treatment at OSF

1 St. Francis Medical Center.

2 We have the same cardiology group now
3 that covers both Peoria and Galesburg. So
4 we're trying to take a more regional approach;
5 and where the expertise is, that's where we
6 really want to send our patients.

7 MEMBER BURDEN: I'm just looking at
8 the time frame. I mean, I'm not a
9 cardiologist, but sooner is always better.

10 If you can get into the emergency room,
11 be seen, and flown to your sister institution,
12 St. Francis -- I presume that's where you're
13 sending them --

14 MR. LIPE: Yes.

15 MEMBER BURDEN: -- that sounds
16 appropriate. That's the first concern I have.

17 Knowing full well, having spent a time
18 in that general community and had a business
19 in Galesburg for a while, although I'm not in
20 that business anymore, but I do know that
21 patients in that area from the university --
22 Knox College is right there -- are apparently
23 95 percent white, which is the group -- that's
24 the group of folks that get coronary artery

1 disease in a rather frequent manner.

2 That's all. You've answered my
3 question.

4 CHAIRPERSON OLSON: Just as a point
5 of clarification, is it correct that in 2011
6 you did zero cardiovascular procedures at this
7 facility? And was that zero again in 2012?

8 MR. LIPE: I think we did five in
9 '11 and zero in 2012.

10 CHAIRPERSON OLSON: Thank you.

11 Other questions? Mr. Penn?

12 MEMBER PENN: Are any of your
13 patients forced to go to Iowa?

14 How close are you to Iowa?

15 MR. LIPE: Well, the Quad Cities is
16 about the same distance as Peoria, about 45
17 miles either direction.

18 MEMBER PENN: Are you aware of any
19 of your patients being out of the insurance
20 network because they have to go to these other
21 facilities, which causes them to have more
22 out-of-pocket expenses because they're not
23 within their insurance company?

24 MR. LIPE: I'm not aware that

1 that's been an issue.

2 CHAIRPERSON OLSON: Mr. Sewell?

3 MEMBER SEWELL: Again, I want to
4 ask: Years ago there was a standard for
5 cardiac catheterization as to how many
6 everybody should be doing before we approved a
7 new one.

8 Do you still have that standard?

9 MR. CONSTANTINO: That's still
10 correct.

11 MEMBER SEWELL: What is the number,
12 200?

13 MR. CONSTANTINO: Yes, sir.

14 MEMBER PENN: Kathy, I didn't hear
15 the question. What was the question?

16 CHAIRPERSON OLSON: Oh, I'm sorry.
17 He wanted to know if our Board standard was
18 200 procedures a year, and that's correct.

19 MEMBER SEWELL: Everyone should be
20 doing 200 before we approve a new one.

21 MEMBER PENN: Okay.

22 MEMBER BURDEN: That's a good
23 question, but we had this issue with the prior
24 application here regarding the numbers of

1 cardiac cath.

2 I don't know how it ever gets -- I don't
3 believe this so-called number, as we were
4 informed -- that was at the beginning of my
5 inception on this Board where we had chiefs of
6 cardiac service present their feelings on how
7 frequent.

8 How did it ever get that hospitals such
9 as yours get to a point where you're only
10 doing 5 or 28 or whatever number?

11 No one has sat down and talked to the
12 cardiac people involved that "Hey, there's not
13 enough getting done for you to be expertise at
14 this." That's not your problem. I'm asking
15 someone should be evaluating this, not us.

16 We have standards. We see them, and we
17 know that as a physician there's no way you
18 can be competent when you're doing five a
19 year. It just doesn't make sense, but no one
20 addresses it.

21 We're asking a question that we can't
22 get an answer to, I believe; is that right?

23 MR. HOHULIN: Right.

24 Mr. LIPE: Yes.

1 MR. URSO: In the past -- it's been
2 a number of years now -- this Board has
3 conducted an audit, so to speak, of the number
4 of procedures that people were doing because
5 they all claimed they were going to meet our
6 targets. A lot of times that does not happen,
7 but at one point we did take a look at cardiac
8 procedures, probably a number years ago.

9 MR. CONSTANTINO: That's correct.

10 MR. URSO: So we do have that
11 ability. It would take some time; but if the
12 desire is there, we could do that.

13 MEMBER BURDEN: Well, I think as a
14 physician I'm not going to be criticizing your
15 cardiac cath procedures and the number; but
16 just as a citizen, I don't know whether we
17 should resume evaluating that. I think it's
18 appropriate.

19 It seems like the institutions
20 themselves should be policing and should be
21 aware that this is not -- a surgeon who
22 doesn't do but 200 of these a year, the
23 Credentials Committee of any institution
24 should be aware. The significance of it is

1 obvious.

2 I don't know if it's our role, but I do
3 agree that what's being done here is more than
4 appropriate as long as the acute chest pain
5 patient can get care and get moved in a timely
6 fashion. That's what I'm concerned about.

7 I do agree with you, but I don't know
8 how we can address that without an internal
9 discussion amongst us and see if it makes
10 sense.

11 We've had two applications today where
12 there's a very low number of cardiac
13 procedures being done and they're both
14 addressing it.

15 CHAIRPERSON OLSON: Good point.
16 It's something that we need to keep on our
17 radar.

18 Further questions?

19 I'd like a motion to approve Project
20 13-024, St. Mary Medical Center for
21 discontinuation of the Cardiac Catheterization
22 category of service.

23 MEMBER BRADLEY: So move.

24 MR. PENN: Second.

13-028 - KINDRED HOSPITAL OF SPRINGFIELD
13-029 - GREATER PEORIA SPECIALTY HOSPITAL

110

1 MR. ROATE: Motion made by
2 Mr. Bradley, seconded by Mr. Penn.

3 CHAIRPERSON OLSON: Roll call,
4 please?

5 MR. ROATE: Mr. Bradley.

6 MEMBER BRADLEY: Yes.

7 MR. ROATE: Dr. Burden.

8 MEMBER BURDEN: Yes.

9 MR. ROATE: Senator Demuzio.

10 SENATOR DEMUZIO: Yes.

11 MR. ROATE: Justice Greiman.

12 MEMBER GREIMAN: Yes.

13 MR. ROATE: Ms. Olson.

14 CHAIRPERSON OLSON: Yes.

15 MR. ROATE: Mr. Penn.

16 MEMBER PENN: Yes.

17 MR. ROATE: Mr. Sewell.

18 MEMBER SEWELL: Yes.

19 MR. ROATE: Seven votes in the
20 affirmative.

21 CHAIRPERSON OLSON: Thank you,
22 gentlemen. The motion passes.

23 Okay. Next we have Item 13-028, Kindred
24 Hospital of Springfield. I believe we're

**13-028 - KINDRED HOSPITAL OF SPRINGFIELD
13-029 - GREATER PEORIA SPECIALTY HOSPITAL**

111

1 going to allow the Board's approval also of
2 No. 13-029, Greater Peoria Specialty Hospital,
3 one presentation but two votes. This is one
4 transaction that's occurring affecting both of
5 these hospitals. So we will hear one
6 presentation.

7 I understand that, Mr. Axel, you're
8 prepared to do that.

9 MR. AXEL: Yes.

10 CHAIRPERSON OLSON: One
11 presentation but we will take two separate
12 votes if the Board is okay with that.

13 Hearing no opposition, that's what we're
14 going to do.

15 Mike, Staff Agency Report?

16 MR. CONSTANTINO: Thank you, Madam
17 Chairwoman.

18 The applicants are proposing a change of
19 ownership of Kindred Hospital in Springfield,
20 Illinois. This is a 50-bed long-term acute
21 care hospital located in Springfield.

22 The proposed cost of the project is
23 approximately \$10.6 million. The anticipated
24 completion date is December 1st, 2013. There

13-028 - KINDRED HOSPITAL OF SPRINGFIELD
13-029 - GREATER PEORIA SPECIALTY HOSPITAL

112

1 is no opposition, and no public hearing was
2 requested for this project.

3 CHAIRPERSON OLSON: Thank you,
4 Mr. Constantino.

5 Then can we have the Staff Agency Report
6 on Greater Peoria Specialty Hospital as well?

7 MR. CONSTANTINO: The applicants
8 are proposing a change of ownership of 51
9 percent of Kindred Hospital Peoria, a 50-bed
10 long-term care hospital located in Peoria,
11 Illinois. The remaining 49 percent membership
12 interest is owned by Methodist Medical Center
13 of Peoria.

14 The proposed cost of the project is
15 approximately \$960,000. Again, the
16 anticipated completion date is December 1st,
17 2013, and, again, no opposition and no public
18 hearing was requested.

19 Thank you.

20 CHAIRPERSON OLSON: Gentlemen, you
21 should introduce yourselves and be sworn in.

22 MR. YOHE: Doug Yohe, Senior Vice
23 President and General Counsel.

24 MR. AXEL: Jack Axel, Axel &

13-028 - KINDRED HOSPITAL OF SPRINGFIELD
13-029 - GREATER PEORIA SPECIALTY HOSPITAL

113

1 Associates.

2 MR. GERICK: Robert Gerick. I'm
3 the Regional Vice President. Robert Gerick,
4 G-e-r-i-c-k, Regional Vice President with
5 Vibra Healthcare, V-i-b-r-a Healthcare.

6 CHAIRPERSON OLSON: Would you raise
7 your right hands to be sworn?

8 (The witnesses were thereupon
9 duly sworn.)

10 MR. YOHE: Members of the Board,
11 good afternoon. Thank you for this
12 opportunity to address you today. I am
13 Douglas Yohe. I'm the Senior Vice President
14 of Vibra Healthcare, and I will be discussing
15 the change of ownership of Kindred Hospital
16 Springfield and Greater Peoria Specialty
17 Hospital, both of which are long-term acute
18 care hospitals.

19 As a bit of introduction, these
20 acquisitions represent Vibra Healthcare's
21 first budgets in Illinois. Vibra Healthcare
22 was formed in June of 2004. We had our first
23 acquisition in July of 2004 of six hospitals.
24 We currently own 15 hospitals, 11 of which are

**13-028 - KINDRED HOSPITAL OF SPRINGFIELD
13-029 - GREATER PEORIA SPECIALTY HOSPITAL**

114

1 long-term acute care hospitals, and four of
2 them are inpatient rehab hospitals.

3 In addition to that, we are involved in
4 a joint venture with an acute care hospital
5 called Summa Health Systems in Akron, Ohio,
6 and that is an inpatient rehab hospital. We
7 currently operate in ten states anywhere from
8 Massachusetts to California.

9 Methodist Medical Center in Peoria has a
10 49 percent interest in Greater Peoria
11 Specialty Hospital, and that will continue
12 with Vibra acquiring Kindred's 51 percent
13 interest in the facility and 100 percent
14 interest in the Springfield long-term acute
15 care hospital.

16 The two Illinois long-term acute care
17 hospitals we address today are part of Vibra's
18 acquisition of a total of 17 facilities
19 currently owned by Kindred Healthcare
20 nationwide. 15 of these 17 facilities being
21 acquired by Vibra are long-term acute care
22 hospitals. Kindred will continue to have four
23 other long-term acute care hospitals in
24 Illinois.

**13-028 - KINDRED HOSPITAL OF SPRINGFIELD
13-029 - GREATER PEORIA SPECIALTY HOSPITAL**

115

1 Because of these changes of ownership,
2 I've received fully positive State Agency
3 Reports; and because there has been no
4 opposition voiced to these changes of
5 ownership, rather than provide a lengthy
6 presentation, we would be happy to simply
7 entertain your questions.

8 Thank You.

9 CHAIRPERSON OLSON: Questions from
10 Board members? Dr. Burden?

11 MEMBER BURDEN: The Vibra Hospital,
12 where is the home office? It's a huge
13 operation, 500 employees. Where is the home
14 office?

15 MR. YOHE: We are based in
16 Canonsburg, Pennsylvania. That is outside of
17 Harrisburg, Pennsylvania, the state capital of
18 Pennsylvania.

19 MEMBER BURDEN: You should know the
20 Harrisburg people run their joint. I'm not
21 buying any municipal bonds out of Harrisburg,
22 I'll tell you that.

23 What I'm questioning here has got little
24 to do with why you're here in a sense.

13-028 - KINDRED HOSPITAL OF SPRINGFIELD
13-029 - GREATER PEORIA SPECIALTY HOSPITAL

116

1 How is it that Kindred had the pretax
2 loss of 100 million bucks? They demonstrate
3 no -- it's a for-profit operation, that's for
4 sure, but it isn't very profitable, if I
5 understand why they're getting bought out.
6 They have no charity care and no Medicaid.

7 I looked at that and I said, "How the
8 hell did this happen? How does an operation
9 lose that kind of money?" We're big on
10 listening to people who take care of the poor.
11 We're very much involved in seeing that that
12 gets done.

13 You guys are buying this thing, and it
14 sounds to me like a pretty good deal for
15 Vibra.

16 MR. YOHE: Unfortunately, I can't
17 comment on that. I work with Vibra
18 Healthcare, not Kindred, with regard to that.

19 MR. AXEL: Dr. Burden, in response
20 to your comment on Medicaid, as noted by
21 Mr. Yohe, Kindred does have six facilities in
22 Illinois, six long-term care acute hospitals,
23 and they do report providing Medicaid at the
24 other four.

13-028 - KINDRED HOSPITAL OF SPRINGFIELD
13-029 - GREATER PEORIA SPECIALTY HOSPITAL

117

1 I think the issue is perhaps some
2 incorrect data provided by Kindred on the two
3 hospitals being discussed today. They both do
4 provide Medicaid services, and it is Vibra's
5 policy to provide both Medicaid and charity
6 care in all of their facilities.

7 MEMBER BURDEN: Again, we're having
8 a typo error, no Medicaid, no charity care.

9 Of course, I'm going to wrap it up by
10 asking: It's an oxymoron for me as a
11 physician to hear about acute long-term care.
12 When the heck did that category evolve?

13 I've been involved in going into a
14 Kindred hospital with a patient of mine once.
15 I saw nothing but tubes and chronic respirator
16 equipment. It's all chronic disease.

17 Is there such a thing as an acute
18 long-term care problem? Tell me. It's an
19 oxymoron. Explain that to me.

20 MR. GERICK: I'll give it a stab.

21 THE REPORTER: Can I have your name
22 again?

23 MR. GERICK: Robert Gerick,
24 G-e-r-i-c-k.

13-028 - KINDRED HOSPITAL OF SPRINGFIELD
13-029 - GREATER PEORIA SPECIALTY HOSPITAL

118

1 I believe it was in the mid-'80s when
2 long-term acute care hospitals evolved, and it
3 really stems from a situation when you have a
4 patient that's in the intensive care unit. As
5 overall health care costs are trying to be
6 reduced and be made more efficient, you don't
7 want to have a patient in the ICU for extended
8 periods of time; but these patients tend to be
9 too ill to go out to a nursing home or to
10 another outpatient modality.

11 Long-term acute care hospitals are,
12 again, licensed by Medicare. It's an acute
13 care hospital just as any of these other
14 short-term acute care hospitals, as we call
15 them, but we have a provision by Medicare that
16 we can care for patients on average with a
17 25-day length of stay instead of the typical
18 four to six days short-term acute cares have.

19 So we fill a specific niche that takes
20 care of a small patient population that really
21 requires the level of care where, as you
22 stated, you have lots of tubes and other
23 things coming out of patients, and they can't
24 be cared for in the nursing home at that

13-028 - KINDRED HOSPITAL OF SPRINGFIELD
13-029 - GREATER PEORIA SPECIALTY HOSPITAL

119

1 level.

2 So we still provide the quality level of
3 acute care needed, but also, then, to keep the
4 costs down in the health care system,
5 long-term acute care has evolved.

6 Since the '80s -- I don't have a graph
7 with me, but I've seen one -- the increase of
8 long-term acute care hospitals has more than
9 doubled in the last 20 years. It's a specific
10 type of care that's definitely need in our
11 system.

12 MEMBER BURDEN: Well, we're all
13 living longer.

14 MR. GERICK: That, too.

15 CHAIRPERSON OLSON: Who was first?

16 MEMBER SEWELL: You were first.

17 CHAIRPERSON OLSON: Mr. Carvalho?

18 MR. CARVALHO: Just to add to that
19 a little bit, as you note -- because,
20 Dr. Burden, you've sat here for a long time --
21 if you scratch the surface, there's always a
22 reimbursement issue underneath.

23 If you recall, in 1980s was also when
24 the DRGs came in. So if a person is admitted

13-028 - KINDRED HOSPITAL OF SPRINGFIELD
13-029 - GREATER PEORIA SPECIALTY HOSPITAL

120

1 to an acute care hospital, there's a DRG
2 associated with that. If they are in a
3 category of health, as described by the
4 applicant, that needs a much longer stay than
5 normal, there's no issue of payment other than
6 outlier payments and things like that.

7 So the niche that this is filling is if
8 you are discharged from an acute care hospital
9 and admitted to a long-term acute care
10 hospital, the meter clicks again. So the
11 acute care hospital -- long-term care hospital
12 will also receive a payment.

13 Everything the applicant said is also
14 true. It's a different level of care. It's
15 higher than a nursing home and all that. So
16 it does fit a medical need as well, but it's
17 an improvement because of this change in
18 reimbursement in the '80s as well.

19 CHAIRPERSON OLSON: Mr. Sewell?

20 MEMBER SEWELL: Is the term
21 "long-stay medical/surgical bed" synonymous
22 with this? Because that's the way I've heard
23 it.

24 MR. YOHE: Not to my knowledge,

13-028 - KINDRED HOSPITAL OF SPRINGFIELD
13-029 - GREATER PEORIA SPECIALTY HOSPITAL

121

1 sir.

2 MEMBER SEWELL: Did I make that up?

3 MR. GERICK: I've not heard of that
4 term other than in some hospitals they may
5 have -- rather than just being called an ICU,
6 they may be called a surgical ICU or an SICU.

7 There's different levels of ICU in the
8 short-term acute care hospital. Ours has
9 always been called long-term acute care, and a
10 certain percentage of our patient population
11 are surgical patients as well.

12 MEMBER SEWELL: David, is this what
13 Bethany did?

14 MR. CARVALHO: Yes, yes.

15 If you recall, if you were on the Board,
16 until we changed our rules, there wasn't a
17 special category for long-term acute care
18 hospitals. We treated them like any other
19 hospital.

20 As you know, in most parts of the state,
21 there is no need to establish an additional
22 hospital. So someone who wanted to come in
23 and establish a long-term acute care hospital
24 was faced with the challenge of having to

13-028 - KINDRED HOSPITAL OF SPRINGFIELD
13-029 - GREATER PEORIA SPECIALTY HOSPITAL

122

1 demonstrate -- say, they wanted to do 50 beds.

2 That 50-bed new hospital was required --
3 and, as I say, in most parts of the state,
4 there weren't new hospitals required. So
5 until we changed our rules, that made it
6 difficult.

7 However, if you had an existing hospital
8 that was already there and you basically
9 wanted to stop doing everything that would
10 make you a regular hospital and only do what
11 would make you a long-term acute care
12 hospital, you could do that.

13 That's what Bethany did. If I recall,
14 there were other hospitals in Illinois that
15 were established that way.

16 MR. AXEL: Holy Family did.

17 MR. CARVALHO: Yeah.

18 So for a short period of time, that was
19 the only way to kind of back into being a
20 long-term acute care hospital. Now we've
21 changed the rules so you can affirmatively
22 apply to be a long-term acute care hospital.

23 CHAIRPERSON OLSON: Thank you.

24 Mr. Penn, do you have any questions?

13-028 - KINDRED HOSPITAL OF SPRINGFIELD
13-029 - GREATER PEORIA SPECIALTY HOSPITAL

123

1 MEMBER PENN: No.

2 CHAIRPERSON OLSON: You looked very
3 pensive there. I thought you had a question.

4 MEMBER SEWELL: Madam Chair, one
5 more question.

6 What is the average length of stay?

7 MR. YOHE: Let me explain that.

8 To maintain our certification with
9 Medicare, we have to average a 25-day average
10 length of stay for a 12-month period. So we
11 can -- again, if we bring somebody in very,
12 very sick and they die after five days, that
13 does count towards that, but usually that's
14 generally how we are certified with Medicare.

15 CHAIRPERSON OLSON: Other questions
16 from Board members?

17 So as promised, we're going to make two
18 motions here. The first motion that I'm
19 looking for is a motion to approve Project
20 13-028, Kindred Hospital of Springfield for a
21 change of ownership of its long-term acute
22 care hospital.

23 MEMBER BRADLEY: I move for
24 approval.

13-028 - KINDRED HOSPITAL OF SPRINGFIELD
13-029 - GREATER PEORIA SPECIALTY HOSPITAL

124

1 MEMBER GREIMAN: Second.

2 MR. ROATE: Motion made by

3 Mr. Bradley, seconded by Mr. Penn.

4 Mr. Bradley.

5 MEMBER BRADLEY: Yes.

6 MR. ROATE: Dr. Burden.

7 MEMBER BURDEN: Yes.

8 MR. ROATE: Senator Demuzio.

9 MEMBER DEMUZIO: Yes.

10 MR. ROATE: Justice Greiman.

11 MEMBER GREIMAN: Yes.

12 MR. ROATE: Ms. Olson.

13 CHAIRPERSON OLSON: Yes.

14 MR. ROATE: Mr. Penn.

15 MEMBER PENN: Yes.

16 MR. ROATE: Mr. Sewell.

17 MEMBER SEWELL: Yes.

18 MR. ROATE: Seven votes in the
19 affirmative.

20 CHAIRPERSON OLSON: Motion passes.

21 I would now entertain a motion to

22 approve Project 13-029, Greater Peoria

23 Specialty Hospital for a change of ownership

24 at its long-term acute care hospital.

13-028 - KINDRED HOSPITAL OF SPRINGFIELD
13-029 - GREATER PEORIA SPECIALTY HOSPITAL

125

1 May I have a motion?

2 MEMBER PENN: So move.

3 CHAIRPERSON OLSON: May I have a
4 second?

5 MEMBER SEWELL: Second.

6 MR. ROATE: Motion made by

7 Mr. Penn, seconded by Mr. Sewell.

8 Mr. Bradley.

9 MEMBER BRADLEY: Yes.

10 MR. ROATE: Dr. Burden.

11 MEMBER BURDEN: Yes.

12 MR. ROATE: Senator Demuzio.

13 MEMBER DEMUZIO: Yes.

14 MR. ROATE: Justice Greiman.

15 MEMBER GREIMAN: Yes.

16 MR. ROATE: Ms. Olson.

17 CHAIRPERSON OLSON: Yes.

18 MR. ROATE: Mr. Penn.

19 MEMBER PENN: Yes.

20 MR. ROATE: Mr. Sewell.

21 MEMBER SEWELL: Yes.

22 MR. ROATE: Seven votes in the
23 affirmative.

24 CHAIRPERSON OLSON: Motion passes.

13-028 - KINDRED HOSPITAL OF SPRINGFIELD
13-029 - GREATER PEORIA SPECIALTY HOSPITAL

126

1 Thank you.

2 MR. YOHE: Thank you.

3 MR. GERICK: Thank you.

4 CHAIRPERSON OLSON: At this time we
5 will recess for lunch. It is 12:15. We will
6 be back in this room and ready to go at 1:30.
7 Thank you.

8 Do I need a motion to adjourn?

9 Is it 12:15?

10 MEMBER GREIMAN: 12:20.

11 CHAIRPERSON OLSON: It is now
12 12:20. I don't know. My watch says -- well,
13 it is almost 12:20.

14 For the record, it's 12:20. We'll be
15 back in this room at 1:30. Thank you.

16 (Whereupon, the hearing was
17 recessed at 12:20 p.m.)

18

19

20

21

22

23

24

13-010 - FMC SCHAUMBURG

127

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24

AFTERNOON SESSION

Tuesday, August 13, 2013

1:32 p.m.

- - - - -

CHAIRPERSON OLSON: We'll come back to order, please. Thank you.

We'll continue with Project 13-010, Fresenius Medical Care, Schaumburg.

Come to the table, please. Fresenius, come to the table.

Mr. Constantino, SAR, please?

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The applicant is proposing the establishment of a 12-station ESRD facility located in Schaumburg, Illinois, in approximately 9,300 gross square feet of leased space.

The approximate cost of the project is \$4.8 million, and the anticipated completion date is December 31, 2014. There was no public hearing requested and no opposition letters received by the State Board Staff.

Thank you, Madam Chairwoman.

1 CHAIRPERSON OLSON: Thank you,
2 Mr. Constantino.

3 If you could introduce yourselves and be
4 sworn in, please.

5 MR. ASAY: My name is Grant Asay,
6 A-s-a-y. With me is Clare Ranalli,
7 R-a-n-a-l-l-i, Laurie Wright, W-r-i-g-h-t, and
8 Colleen Muldoon, M-u-l-d-o-o-n.

9 (The witnesses were thereupon
10 duly sworn.)

11 CHAIRPERSON OLSON: Comments for
12 the Board?

13 MR. ASAY: Good afternoon. Thank
14 you for the opportunity to present.

15 We acknowledge the State Board Report
16 has identified excess capacity in the
17 30-minute travel radius from our proposed
18 Schaumburg site. However, your inventory
19 reflects a need for stations in this
20 particular service area.

21 Despite the current excess capacity at
22 some area clinics, we have seen our dialysis
23 clinics located in and around Schaumburg
24 experience high utilization. We believe the

13-010 - FMC SCHAUMBURG

129

1 proposed clinic will provide better access to
2 dialysis service and will address the need as
3 reflected in your inventory.

4 Thank you for your consideration, and
5 we're available for any questions you might
6 have.

7 CHAIRPERSON OLSON: Thank you.

8 Questions from the Board?

9 Dr. Burden?

10 MEMBER BURDEN: Sir, thank you very
11 much for your opening statements, but the
12 calculated need for ESRD stations is based on
13 a ten-year projection, which my understanding
14 is that's going to be changed.

15 And based on a ten-year projection, I
16 don't know how anybody can predict what need
17 will be in most situations in today's
18 environment. So I have a little problem with
19 that personally, especially since the planning
20 area need and maldistribution take issue with
21 this statement.

22 So when we have a legitimate, I think --
23 more than legitimate planning area projection,
24 I think we can be more -- I can be more

13-010 - FMC SCHAUMBURG

130

1 supportive of your statement, mainly the need,
2 but I have a problem when it's a ten-year
3 projection. That's me.

4 I think that the planning area need and
5 the maldistribution data are more important --
6 or weigh more heavily.

7 CHAIRPERSON OLSON: Other
8 questions/comments by the Board?

9 I actually have a question. Is this, in
10 essence, the same project as 12-015 that was
11 denied in July and October of 2012 or is it a
12 different project?

13 MS. RANALLI: It's the same one.

14 CHAIRPERSON OLSON: Thank you.

15 Other questions from the Board?

16 Justice?

17 MEMBER GREIMAN: We noted that your
18 statement of your company for charity all over
19 the state has gone down from 1 percent, which
20 is not exactly charity, to .2 percent, which
21 is basically zero.

22 So you have no charity care, then; is
23 that right? That's fair to say?

24 MS. RANALLI: Well, I think there

1 is some charity care.

2 As we have said in the past, if you look
3 at our Medicaid numbers, they have gone up
4 quite a bit over the same period of time. The
5 reimbursement to dialysis is somewhat unique
6 in that most of these people are afforded
7 coverage through the Medicare program.

8 MEMBER GREIMAN: Your lawyers put
9 them on Medicare?

10 MS. RANALLI: We don't put them on
11 Medicare. That decision was made a
12 long time ago by the legislative body.

13 MEMBER GREIMAN: One of the things
14 we have in our rules is that we have to show a
15 reason for not going along with our policies,
16 if we change our policy.

17 In this case you have a vast number of
18 spots within a very close area. Just take the
19 ones that are 15 minutes apart. Two of them
20 are zeros already and yours are doing great,
21 but other ones are doing 61 percent, 21
22 percent, and 64 percent. They're not doing
23 very well.

24 So what are we doing? What policy

1 should we use to change and break our rule?

2 MS. RANALLI: In the facilities
3 that you're referring to -- and this is where,
4 again, we do respect the fact that this chart
5 shows maldistribution.

6 If there weren't a need and if we
7 hadn't -- I think this is the third time we've
8 been in front of you for Schaumburg. So you
9 could say we're tenacious and maybe just not
10 getting the message, but we've over time
11 significantly been told by physicians and
12 patients in the area that there's a need.

13 The DaVita Schaumburg clinic just added
14 six stations. It was at 90 percent,
15 approximately. I'm not sure when they
16 appeared before you and requested six
17 stations. So their utilization has dropped
18 down because those stations just went online
19 not too long ago.

20 The USRC Streamwood Dialysis facility
21 has not even been open a year. It's 30
22 percent. So that's the reason that you see
23 those numbers and then the two Fresenius
24 clinics at 92, 92. It's a very densely

13-010 - FMC SCHAUMBURG

133

1 populated area. There are two hospitals. So
2 a lot of patients don't migrate out of the
3 Schaumburg area for care, which is why you
4 have those kind of clinics operating at the 90
5 percent level, except USRC Streamwood, which,
6 again, is in that ramp-up period.

7 I don't know if that answers your
8 question.

9 MEMBER GREIMAN: Close.

10 CHAIRPERSON OLSON: Other questions
11 from the Board?

12 Okay. May I have a motion to approve
13 Project 13-010, Fresenius Medical Care
14 Schaumburg to establish a 12-station ESRD
15 facility?

16 MEMBER BRADLEY: I so move.

17 MEMBER BURDEN: Second.

18 CHAIRPERSON OLSON: Roll call,
19 please?

20 MR. ROATE: Motion made by
21 Mr. Bradley, seconded by Dr. Burden.

22 Mr. Bradley.

23 MEMBER BRADLEY: Yes.

24 MR. ROATE: Dr. Burden.

13-010 - FMC SCHAUMBURG

134

1 MEMBER BURDEN: No, based on the
2 fact this project has been here in July 2014,
3 July 2012, October 2012, planning area need,
4 and unnecessary duplication of service.

5 In time, I think this may well be a
6 thing that could go forward but not at this
7 time, no.

8 MR. ROATE: Senator Demuzio.

9 MEMBER DEMUZIO: No.
10 Unnecessary duplication of services.

11 MR. ROATE: Thank you.

12 Justice Greiman.

13 MEMBER GREIMAN: No.

14 I think it's close. I think that maybe
15 you should have an opportunity to compete, but
16 I think at this point it's just so contrary to
17 our rules without something special coming in
18 to change our minds, which we'll learn about
19 in the next one.

20 MR. ROATE: Thank you, sir.

21 Ms. Olson.

22 CHAIRPERSON OLSON: No, based on
23 the negative findings in the State Agency
24 Report.

13-018 - LUTHER OAKS, INC.

135

1 MR. ROATE: Thank you, Madam.

2 Mr. Penn.

3 MEMBER PENN: No, based on the data
4 findings in the report.

5 MR. ROATE: Mr. Sewell.

6 MEMBER SEWELL: No, for the reasons
7 stated.

8 MR. ROATE: One vote in the
9 affirmative, six votes in the negative.

10 CHAIRPERSON OLSON: The vote fails,
11 and you will be given an intent to deny.

12 MS. RANALLI: Thank you.

13 MR. URSO: You'll have another
14 opportunity to come before the Board and
15 supply information. Thank you.

16 CHAIRPERSON OLSON: Next up we have
17 13-018, Luther Oaks, Incorporated.

18 Mr. Constantino, the State Agency
19 Report?

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

22 The applicants are proposing to
23 establish a 36-bed skilled nursing facility in
24 Bloomington, Illinois. The total cost of the

1 project is approximately \$9.5 million. The
2 expected project completion date is January
3 31, 2015.

4 I would like to note that last week we
5 sent you two comments on the State Board Staff
6 Report, but I believe they were timely
7 submitted and in compliance with our rules,
8 and they should be included in the State Board
9 material.

10 CHAIRPERSON OLSON: So do we need a
11 motion?

12 MR. CONSTANTINO: I believe we do.

13 MR. URSO: Yes. You need to have a
14 motion to accept these documents and consider
15 the project or accept the documents and send
16 them back to Staff for further analysis. So
17 one of those two choices.

18 CHAIRPERSON OLSON: Did everybody
19 get a chance to see those documents? I
20 somehow missed this. I did not see those.

21 Are we comfortable, then, accepting them
22 into the record and proceeding with this
23 application?

24 MEMBER SEWELL: I move we accept

1 them.

2 CHAIRPERSON OLSON: Can I have a
3 second?

4 MEMBER PENN: Second.

5 CHAIRPERSON OLSON: And I can do a
6 voice vote on that?

7 All in favor say aye.

8 (The ayes were thereupon
9 heard.)

10 CHAIRPERSON OLSON: Opposed, nay?
11 The comments will be included in the
12 record.

13 You can continue.

14 MR. CONSTANTINO: Thank you.

15 I would like to make a couple comments
16 regarding those letters. The first comment
17 I'd like to make, there was an accusation made
18 that the applicants have not met the financial
19 requirements. They did not meet the financial
20 ratios, that's correct.

21 However, they were able to provide us
22 with us a loan commit document. In other
23 words, they have a secured loan commitment.
24 It memorializes that they will have the money

1 to do this project.

2 The second point that was made regarding
3 that was the fact that it wasn't for the
4 amount listed in the application. The
5 applicants still have offers out there or
6 options for additional financing, which may in
7 fact reduce the costs further than what was
8 provided to us last week -- or the week
9 before. I'm sorry.

10 So in my opinion, I felt it was
11 necessary to bring the application to you with
12 that firm loan commitment even though they
13 still had offers there that they can reduce
14 the project costs further. If they do that,
15 they will have to alter the project and bring
16 that to the Board.

17 So there is still a chance that this
18 project might cost less than what's been
19 proposed to you based upon the financing.

20 CHAIRPERSON OLSON: The applicant
21 understands that if that changes, they would
22 have to come back to the Board?

23 MR. CONSTANTINO: Oh, yes. That's
24 part of your rules. That's an alteration, and

1 all alterations have to be reported to us.

2 MR. URSO: She's asking the
3 applicant.

4 MR. CONSTANTINO: Oh, I'm sorry.

5 MR. URSO: Do we have an
6 affirmation?

7 CHAIRPERSON OLSON: Actually, do we
8 need to swear them in?

9 (The witnesses were thereupon
10 duly sworn.)

11 CHAIRPERSON OLSON: Then would you
12 introduce yourselves?

13 MS. BROWN: Yes. I'm Gretchen
14 Brown. I'm the administrator for Luther Oaks.

15 MR. HOLBROOK: Jim Holbrook,
16 H-o-l-b-r-o-o-k, Senior Vice President of
17 Corporate Operations, Lutheran Life
18 Communities and Luther Oaks.

19 CHAIRPERSON OLSON: I don't think
20 that mic is working. So maybe you guys can
21 use your outside voices.

22 MR. HOLBROOK: Okay.

23 MR. TECSON: Andrew Tecson,
24 T-e-c-s-o-n, attorney for the applicant.

1 MR. MOELLENKAMP: Carl Moellenkamp,
2 M-o-e-l-l-e-n-k-a-m-p. I'm the Chief
3 Financial Officer for Lutheran Life Ministries
4 as well as Luther Oaks.

5 MR. MADALINSKI: Kevin Madalinski,
6 M-a-d-a-l-i-n-s-k-i, Senior Project Manager
7 with Hoffman Planning Design & Construction.

8 CHAIRPERSON OLSON: Now that you
9 are sworn in, you can tell us that you
10 understand that if your project changes, the
11 cost, that you will have to come back to the
12 Board. Knowing that, you still choose to
13 proceed. I guess that's two questions.

14 MR. TECSON: Yes. It's the
15 aggregate project cost, correct.

16 In other words, we haven't done our bid
17 for construction. That number might be more
18 or less than our projections. The financing
19 might be more or less.

20 But my understanding is under the Board
21 rules, you look at the aggregate cost, and
22 then you have some leeway, X percent. So we
23 would follow those rules.

24 CHAIRPERSON OLSON: Total project

1 cost?

2 MR. TECSON: Yes, total project
3 cost.

4 MR. CONSTANTINO: The second thing,
5 it was identified in the letter that there was
6 a zoning issue.

7 When I spoke to the applicants yesterday
8 about this, they said they were taking it to
9 the City Council yesterday evening. I don't
10 know if it has been approved or not.

11 CHAIRPERSON OLSON: Can we get an
12 answer?

13 MS. BROWN: Yes, we were approved
14 for zoning last night at the City Council
15 meeting.

16 MR. URSO: Can you send us
17 something in writing in that regard?

18 MR. TECSON: We will do that. It
19 was approved last night, so we have done that
20 yet, but absolutely.

21 MR. CONSTANTINO: There was also a
22 statement made about the CCRC.

23 There is a calculated need of 188 beds
24 in the long-term care planning area. The CCRC

1 variance is only applicable when there is no
2 need for long-term care beds. The applicants
3 did not need to file under the CCRC variance.
4 That's why they did not address it.

5 CHAIRPERSON OLSON: If there was
6 not a bed need, then they would have had to
7 file under that variance?

8 MR. CONSTANTINO: Yes, under that
9 variance. It's a variance to compute the bed
10 need.

11 CHAIRPERSON OLSON: Do you
12 understand that? Okay.

13 Dr. Burden?

14 MEMBER BURDEN: Madam Chair, thank
15 you.

16 Mr. Constantino, Page 2, there's a
17 sentence there I'd refer you to in lieu of
18 Table One. The last sentence states that
19 there are 13 providers of long-term care
20 services that are operating at 90 percent
21 target occupancy. The table doesn't agree
22 with that.

23 MR. CONSTANTINO: That's incorrect.
24 That was a mistake.

1 MEMBER BURDEN: Thank you. At
2 least we admit to a mistake. Thank you.

3 MR. CONSTANTINO: My good friend,
4 Dr. Burden, has to bring these up, but that is
5 true, my close dear friend.

6 CHAIRPERSON OLSON: Do we want to
7 let them do a statement?

8 Go ahead, Justice.

9 MEMBER GREIMAN: I wanted to ask a
10 question of them. We've heard enough from
11 them already in the beginning. We heard a lot
12 of people talk.

13 You were here a few minutes ago when we
14 voted down a request because they had
15 sufficient people doing the work in the area.
16 We're faced sort of with the same issue here,
17 and it's our obligation to tell people why
18 we're doing things.

19 What is the reason why you should be
20 different than the last one?

21 MS. BROWN: We have several reasons
22 that we feel we're distinguishing a different
23 level of service in the provider area.

24 First and foremost, this will be a

1 faith-based skilled care nursing setting.
2 That is not something that is here in the
3 Bloomington-Normal area.

4 Secondly, we are developing the resident
5 center care model, which is not only supported
6 by the environment that we are doing as far as
7 the household construction but also how we
8 staff.

9 We staff with two specific resident
10 center care teams that provide a level of
11 consistency for those residents on a routine
12 basis.

13 Lastly, we are definitely looking to
14 meet the need of the dementia skilled care
15 need in the area. We will be able to make
16 that part of our full continuum.

17 We currently have dementia care services
18 in our assisted living, and we would continue
19 that in our traditional long-term care with
20 these additional 36 that we're adding.

21 On top of that, the private bed need in
22 the area has also been identified with
23 currently only 10 percent of the total beds in
24 the area being designated as private rooms.

13-018 - LUTHER OAKS, INC.

145

1 So we would add 34 privates, and then we would
2 add those to the occupancy.

3 That's it in a nutshell.

4 MEMBER GREIMAN: Thank you.

5 CHAIRPERSON OLSON: Do you have any
6 other comments?

7 MR. CONSTANTINO: No.

8 CHAIRPERSON OLSON: Would you like
9 to make a statement or did you just kind of do
10 it? It's up to you.

11 MS. BROWN: I kind of did it in
12 summary, but I would like to, yes, if it's
13 okay.

14 CHAIRPERSON OLSON: Okay. Please.

15 MS. BROWN: I think I've already
16 introduced myself. I am the Campus
17 Administrator at Luther Oaks.

18 We obviously are here to ask your
19 approval for our 36-bed nursing community as
20 part of our current campus in Bloomington,
21 Illinois.

22 We are here to just address some of the
23 questions that were had and also address some
24 of the comments in the opposition and just

1 remind the Board there was only one opposition
2 to this being built.

3 Our new skilled nursing facility is
4 going to be located on our campus. We opened
5 in 2007 with 90 independent-living apartments
6 and 58 assisted living apartments.

7 We phased the project when we first
8 built so that the independent-living and the
9 assisted-living apartments would reach 90
10 percent occupancy prior to seeking approval to
11 construct the skilled nursing component of our
12 campus.

13 By phasing the campus in this fashion,
14 we did not run the risk of having skilled
15 nursing beds stand empty until our residents
16 aged in place to a point where they require
17 such care.

18 At this time we have a demand for
19 skilled nursing services not only from our
20 existing residents but also the demand that
21 the community has emphasized, as evidenced by
22 the over 130 letters of support for this
23 project.

24 We are not a not-for-profit faith-based

1 community, and we are part of Lutheran Life
2 Communities system, which provides faith-based
3 not-for-profit senior living services
4 throughout the system.

5 Our mission is to empower grace-filled
6 living across all generations. As part of our
7 faith-based ministries, we seek to provide an
8 environment that enhances not only the
9 physical well-being of the residents but also
10 their spiritual well-being.

11 If approved, we will have an on-site
12 chaplain as part of our staff who will
13 administer to the spiritual needs of
14 residents.

15 Throughout the Lutheran Life Communities
16 campuses, we endeavor to provide quality care
17 to all of our residents, even those who have
18 outlived their resources. If approved, we
19 will be the only faith-based not-for-profit
20 skilled care community this area.

21 This project is very modest in size. It
22 will have a large impact on existing residents
23 and the community that we serve. The new
24 facility will be intentionally designed to

1 facilitate a person-centered health care
2 delivery model, which means that the
3 environment in the facility is as home-like as
4 possible and the residents have significant
5 control in driving all aspects of their care.

6 We will have private rooms with private
7 bathrooms for almost all the residents. In
8 addition, residents receiving rehabilitation
9 services will have the benefit of private
10 showers, thus enhancing resident privacy,
11 dignity, and quality of care.

12 Private rooms are important not only for
13 our residents' comfort but are critical in
14 maintaining residents' privacy and increasing
15 our ability to control infections.

16 The proposed facility will have
17 basically two residential neighborhoods with a
18 maximum of 20 residents in one neighborhood
19 and 16 in the second. Each will have a
20 central common area with home-like furnishings
21 and design, which will permit residents to
22 gather to dine, obtain a snack from the
23 kitchenette 24/7, and socialize with friends,
24 families, and other residents.

1 Our resident-centered staffing model
2 allows us to schedule staff in two teams so
3 the same caregivers will be caring for the
4 same residents on a consistent basis.

5 This means not only that the staff
6 becomes very familiar with the preferences and
7 capacities of each resident, but it increases
8 the quality of care because staff can
9 anticipate the daily activities of each
10 resident and know how to assist the resident
11 with avoiding falls and other negative
12 outcomes.

13 In addition, the nurses' familiarity
14 with the resident allows for an expedited
15 response to any change in the resident's
16 condition.

17 The addition of this new skilled nursing
18 facility is absolutely critical to the
19 economic viability of Luther Oaks. The
20 existing residents will be able to receive
21 skilled care on the campus so they can be with
22 their spouse and support network during health
23 changes.

24 If skilled care is not added, we will

1 lose current residents and potential new
2 residents. Many people will be deterred from
3 choosing us in the future if we do not have
4 skilled care on the campus. We are already
5 seeing this in our marketing inquiries.

6 CHAIRPERSON OLSON: Additional
7 comments or questions?

8 Questions from the Board?

9 Dr. Burden?

10 MEMBER BURDEN: I certainly
11 appreciate the faith-based need. As I
12 approach my ninth decade, I recognize that
13 this might be coming for me in the
14 not-too-distant future.

15 My question still comes back to the fact
16 we have 188 long-term beds, which is a
17 ten-year projection, and I've never been able
18 to figure that out.

19 How did you come up with the number of
20 36 skilled nursing beds?

21 We were already faced to consider your
22 application, and there's not one of the
23 long-term care facilities within 30 minutes
24 that has met the 90 percent standard. I'm

1 curious.

2 Why that number, which is a pretty big
3 number when you view what we're looking at
4 here?

5 MS. BROWN: When we looked into the
6 project, the main reason that we pulled the 36
7 number had a lot to do -- actually, everything
8 to do from a staffing ratio and staffing
9 efficiency to support the two different
10 designated types of residents that we want to
11 serve, the short-term rehab as well as the
12 long-term traditional and dementia care.

13 So when you look at the ratios between
14 nurses and CNAs, we typically see in a
15 household setting that they talk to somewhere
16 between 12 and 14 residents.

17 From a staff efficiency and at our other
18 campuses, we typically run a 1 to 16 ratio in
19 a short-term rehab with a nurse, with two
20 CNAs. Then on our long-term, that typically
21 is more of a 1 to 18 to 20 nurse ratio.

22 So we looked at those from staff
23 efficiency and operational efficiency.

24 MEMBER BURDEN: My next question

1 is: In your community are there specific
2 skilled nursing facilities devoted towards
3 Alzheimer's and/or dementia care specifically?

4 MS. BROWN: They have that level of
5 care on their campus, yes.

6 As far as specifically, I'm not sure.
7 They have that incorporated within their skill
8 care areas.

9 MEMBER BURDEN: So the answer is
10 not what I'm looking for.

11 There are -- in the Chicago community,
12 I'm well aware of more than a few skilled
13 nursing facilities that devote themselves
14 entirely to alcohol dementia, although it
15 turns out to be more Alzheimer's.

16 What I'm looking for is a skilled
17 nursing facility dedicated specifically.
18 Maybe the population doesn't require such.

19 Your answer is that there are such
20 available to care for these patients, but
21 there is no specific unit that does nothing
22 but care for those types patients?

23 MS. BROWN: I believe that there
24 are two of the communities -- this is to my

1 best knowledge right now -- that have
2 designated wings for skilled dementia care.

3 Those are typically -- what we know is
4 they're running 96 percent and 100 percent
5 occupied; but within 15-minute drive time of
6 Luther Oaks, there are not any. So that's
7 outside the 15-minute drive time of Luther
8 Oaks.

9 MEMBER BURDEN: Thank you.

10 CHAIRPERSON OLSON: Senator
11 Demuzio?

12 MEMBER DEMUZIO: I'm just looking
13 here at our report and I notice that on
14 Page 4, the second paragraph, it states that
15 "Luther Oaks, whatever its reasoning,
16 established itself in the Bloomington
17 community as a CCRC to be a source of
18 independent living and assisted living but
19 without offering skilled nursing care."

20 Then it goes on to say that "Health care
21 delivery in Health Service Area 4 developed
22 accordingly with other providers establishing
23 facilities to provide skilled nursing care.
24 This project threatens to adversely impact the

1 balance established within this community."

2 Can you explain that to me? I'm new.

3 Can you explain what that means?

4 Are you skilled?

5 How do you adversely impact this
6 community?

7 MS. BROWN: I'm not sure if I know
8 how to answer that question.

9 If I understand it correctly, clearly
10 we're here to have the skilled care approved.
11 So no, we do not have skilled care at our
12 campus at this time.

13 We are strictly independent living, and
14 we have licensed assisted living with 18 of
15 our 58 assisted livings that are licensed
16 assisted living and are specific for dementia
17 care.

18 MEMBER DEMUZIO: Okay. Thank you
19 very much.

20 CHAIRPERSON OLSON: Mr. Penn?

21 MEMBER PENN: Good afternoon.

22 I can appreciate the project, the jobs
23 it's going to create for Bloomington-Normal,
24 my hometown, but unfortunately I'm not wearing

1 that hat today.

2 I was taken aback about the way you
3 painted the rest of the facilities in this
4 community. I strongly disagree with the
5 presentation.

6 I have senior parents. I visit other
7 facilities in this community, in this planning
8 area. I visit patients who are residents
9 there; and as one of four siblings, we may be
10 facing the same situation with my parents.

11 I don't have the same outlook on these
12 facilities that you have. I think they
13 provide better than average care, great care,
14 skills provided for the patients, residents.

15 So it comes down to me this is
16 maldistribution. Hearing both the public
17 comments for and against, I wasn't swayed that
18 your facility was going to be so much better
19 that it would be necessary that you build this
20 and have such a great negative impact on the
21 rest of these nursing homes.

22 I'd like for you to make a comment about
23 this.

24 MS. BROWN: We feel that if we had

1 gone under the variance, let's say -- and we
2 already indicated why we did not do that. We
3 weren't required to do that -- we would have
4 been eligible for 29 beds. We are looking at
5 36, which I explained from an efficiency and
6 staffing point of view.

7 The impact that we have seen with our
8 residents that currently go to other
9 communities from Luther Oaks -- they have gone
10 to local places, and they've gone outside the
11 Bloomington-Normal area. We have found that
12 impact to be negligible on the others.

13 I'm trying to see if we had any percent.
14 It ended up being -- the last two years, I
15 believe we had 19 residents leave the Luther
16 Oaks campus to other communities, and we
17 looked at that. I don't have that in front of
18 me. It was one to two through various
19 communities over a two-year period.

20 So that's why we feel the impact was
21 negligible on the others.

22 MEMBER PENN: I still -- I'm not
23 trying to make my vote here with this
24 conversation, but I was almost offended by the

1 way you presented Luther Oaks versus the other
2 facilities.

3 I have no financial interest in these
4 other facilities other than the fact that
5 someday my parents may be there and I'd make
6 continued visits. I find those facilities to
7 be, you know, good establishments. They
8 provide great care.

9 So now I look at do we need to expand
10 here and have a great negative impact on these
11 other facilities?

12 MS. BROWN: Certainly, our intent
13 was not to have any kind of ill feeling
14 towards the other communities in town.

15 We looked at the four- and five-star
16 ratings in the area. You do have communities
17 within Bloomington-Normal that do not meet
18 that rating.

19 As far as Lutheran Life Communities, of
20 the communities that are within the state of
21 Illinois, all of our communities have four-
22 and five-star ratings under the Medicare
23 rating system.

24 Also, because of the services that we

1 provide, our communities are running at
2 90 percent or better this last fiscal year in
3 occupancy.

4 MEMBER PENN: I appreciate the star
5 rating; but when I go on property and visit
6 the clients, the residents, I've yet had one
7 person tell me "I need to get out of here.
8 "This does not fit our family needs" or
9 "budget" or whatever it might be. They all
10 seem to be very satisfied with the care they
11 are getting at these other facilities.

12 MS. BROWN: I appreciate that
13 comment.

14 When we looked at what distinguishes us
15 right now even in the assisted living arena,
16 you know, we have 100 percent of our families
17 and our residents satisfied with the services
18 that they receive at Luther Oaks.

19 When we look at our dementia care
20 programming that we currently provide, we are
21 utilizing what is considered the RCCT
22 programming for what you work with in life
23 enrichment. It is a very individualized
24 approach. We look at how we staff with the

1 two teams specific for continuity of care.

2 Those two pieces right there as well as
3 increasing the private bed need I feel does
4 distinguish us and allows us to provide a --
5 it assures a quality level of service.

6 MEMBER PENN: Just hypothetically,
7 Heritage, if they had presented the same
8 proposal as you are presenting, would you be
9 in support of them doing a project which would
10 have a negative impact on your facility?

11 If they were to provide the same campus,
12 same room size, so forth, would you be here
13 supporting them, just hypothetically?

14 MS. BROWN: It is hypothetical.

15 My comment to that would be that they're
16 not in the same building. We're looking to
17 have this level of service within our campus;
18 and if Heritage is doing it, they already have
19 what they have.

20 MEMBER PENN: I'm just trying to
21 understand this situation we're in.

22 If Heritage had come in with this
23 application, was on your campus, expand 36
24 beds and provide those services, would you

1 think it was a good idea for them to do that
2 if it would have a negative impact on your
3 property?

4 MR. HOLBROOK: Jim Holbrook,
5 H-o-l-b-r-o-o-k.

6 You know, it is very hypothetical from
7 that perspective. The main reason that we are
8 pursuing bringing skilled care to our campus
9 for Luther Oaks is because the residents there
10 want that. That's what they desired when they
11 came to live with us.

12 Certainly, if people at Heritage saw
13 that desire and made that aware to their
14 administration that that was a need that they
15 had, we would definitely look at that in terms
16 of how that would impact us, but we don't have
17 skilled care at this point.

18 So the impact on us at this point
19 wouldn't be -- there would be no impact
20 because we don't have skilled care. I'd have
21 to cross that bridge when we got to that.

22 CHAIRPERSON OLSON: Can I just add
23 something into the mix here?

24 I understand that you did not have to

1 apply under the CCRC variance, but I'm hearing
2 that if you had, you could have justified 29
3 beds; is that correct?

4 MS. BROWN: Correct.

5 CHAIRPERSON OLSON: So is it
6 possible that -- and I'm hearing from Frank
7 that perhaps it is possible -- we could
8 approve the 29 beds under a CCRC, if you'd be
9 willing to go that direction?

10 I'm just sort of throwing it out there,
11 food for thought.

12 MS. BROWN: Our concern, in
13 addition to what we're trying to accomplish
14 not only with having a faith-based
15 organization but also from a staff efficiency
16 point of view of how you staff that area when
17 you're reducing that by seven, is also the
18 fact that when you're dealing with short-term
19 rehabilitation, the length of stay for those
20 residents is much less.

21 We don't feel we would have the volume
22 internally to support a short-term rehab, and
23 that is a service that we want to be able to
24 provide.

1 CHAIRPERSON OLSON: So you're
2 saying you would not consider it?

3 MS. BROWN: Correct.

4 CHAIRPERSON OLSON: I have just a
5 couple questions.

6 First of all, I want to make sure I
7 understand something that I think I heard you
8 say. 10 percent of the available beds
9 currently -- or only 10 percent are private
10 rooms?

11 MS. BROWN: Yes. 161 beds, I
12 believe, yes.

13 CHAIRPERSON OLSON: Then if you can
14 help me, on Page 3 of the SAR, I'm seeing that
15 6 of the 13 facilities that are in capacity
16 have a 1 or 2 Medicare rating.

17 I don't know whether, to Mr. Penn's
18 point, you can walk in and it's fine, but
19 obviously Medicare has a rating for great
20 reason.

21 I also want to know because I believe,
22 from looking at some of these facilities and
23 being somewhat familiar, that there are some
24 of these facilities here who perhaps are just

1 for mentally ill patients, don't even
2 accept -- or am I incorrect in that
3 assumption?

4 MS. BROWN: I'm trying to
5 recollect. I believe there's one of the
6 communities in particular that's primarily
7 mental health.

8 CHAIRPERSON OLSON: Symphony of
9 Lincoln? Or DD? Are some of these DD?

10 MS. BROWN: I don't have that
11 information in front of me. I apologize.

12 MR. CONSTANTINO: They are skilled
13 care facilities.

14 CHAIRPERSON OLSON: I know, but you
15 can be licensed -- maybe Frank can help me.
16 You can be licensed --

17 MS. BROWN: We're looking up that
18 information.

19 CHAIRPERSON OLSON: -- ICF/DD

20 MR. CONSTANTINO: That's not
21 included in our report.

22 CHAIRPERSON OLSON: That would not
23 be included. That was my question.

24 Mr. Carvalho, did you have something to

1 add?

2 MR. CARVALHO: Thank you, Madam
3 Chair. Just a couple questions and also to
4 clarify some things.

5 First off, almost once a meeting I have
6 to say this. I guess this is the
7 once-a-meeting time. We have multiple tests
8 of need. It's not "any of the above." It's
9 "all of the above."

10 So we look both at bed need and
11 inventory, but we also look at occupancy. So
12 it's not a case of, "Well, we at least met
13 one." The standard is supposed to be you meet
14 them all.

15 Second, if you had chosen to do a CCRC,
16 you would have also have then had to live with
17 the restrictions of a CCRC, which is that the
18 beds are only available for the services to
19 the persons who live in the CCRC.

20 So your application, I believe, is
21 seeking to use these beds for everybody;
22 right?

23 MS. BROWN: That's correct.

24 MR. CARVALHO: One of the things in

1 the CCRC -- and this is built right into it,
2 and everybody who applies as a CCRC accepts
3 that -- is when you open a CCRC, you want to
4 build the number of beds that you think you're
5 going to need over the life cycle of the CCRC.

6 But you know the people are not going to
7 be moving in -- you don't expect people to be
8 moving in in the demographic that you're going
9 to look like 50 years from now. In fact, most
10 of the people moving in are going to be at the
11 other end.

12 So everybody else who builds a CCRC
13 builds into the economics of it that they're
14 going to have these expenditures, beds going
15 unused for a while, that they're going to
16 carry the cost of the construction and all
17 that, but nonetheless, people are building
18 CCRCs. That's part of the economics of it.

19 So you avoided the part where you had to
20 carry the cost, and now you're seeking to
21 avoid the restriction that the beds are only
22 used for the people in the CCRC. I think it's
23 important to bring that out.

24 When did the CCRC open?

1 MS. BROWN: The independent living
2 opened in 2007 in August, and assisted living
3 opened in November that same year.

4 MR. CARVALHO: In your marketing
5 materials to the people residing there now,
6 were there promises made that there was going
7 to be a nursing component or down the road we
8 would apply for nursing?

9 MR. HOLBROOK: The commitment that
10 was made to our residents at the time was that
11 when we reached stabilized occupancy, we would
12 move forward with a skilled nursing facility
13 on the campus.

14 That was due in part because stabilized
15 occupancy put us in a position where we could
16 do that.

17 MR. CARVALHO: Financially?

18 MR. HOLBROOK: Financially.

19 MR. CARVALHO: So did you make --
20 since you know you can't do that without
21 permission, without a Certificate of Need, did
22 you explain that to people that "This is
23 something that we don't have but we hope to
24 have if we can get Commission approval"?

1 MR. HOLBROOK: Yes.

2 MR. CARVALHO: At the time you did
3 that, when you applied in -- when did you
4 apply to the Commission? '06?

5 MR. HOLBROOK: 2004 is when we
6 started the process.

7 MR. CARVALHO: Would you have
8 qualified to build nursing home beds at the
9 time? Would you need a determination at the
10 time?

11 MR. HOLBROOK: I don't know. We
12 weren't required at that time because we
13 didn't build it.

14 MR. CARVALHO: I'll stop there.
15 Thanks.

16 CHAIRPERSON OLSON: Any other
17 questions?

18 MEMBER BRADLEY: I'm troubled by
19 the discussions of this being a faith-based
20 institution.

21 Is there anything in our rules and
22 regulations which gives any deference to a
23 faith-based organization?

24 MR. CONSTANTINO: We have a defined

1 variance for religious groups. However,
2 that's, again, a variance to the computed bed
3 need. There is a need for 188 beds in this
4 planning area.

5 MEMBER BRADLEY: So they're not
6 applying for any variance?

7 MR. CONSTANTINO: No, sir.

8 MEMBER BRADLEY: We've had a
9 discussion of the need for a faith-based
10 organization, and we've had a discussion of
11 the fact that it may have a negative impact on
12 other institutions in the area.

13 It seems to me that if we go towards the
14 argument that this is needed in part because
15 it's a faith-based organization, we are acting
16 in a way that's detrimental to organizations
17 which aren't faith based.

18 It may be perceived as being somewhat
19 discriminatory on the basis of something that
20 really isn't part of the rules and regulations
21 that should be applied here.

22 We got into this in another area a few
23 meetings ago where there were arguments
24 brought forth about the need for something in

1 part because of religious connotations and
2 their practices.

3 I think it's very dangerous for a public
4 body to be discussing and perhaps making
5 decisions based on whether they'd benefit a
6 faith-based organization, particularly if they
7 may have a negative impact on organizations
8 which are not faith based.

9 So I just raise that as a cautionary
10 note as we look at this and as we go on to
11 just talk about other institutions in various
12 areas.

13 MR. URSO: I just have a question.

14 On some of the comments that we
15 received, it talked about the conditional
16 nature of referrals based upon a four-star
17 rating.

18 Do you know what that's about?

19 And is that true that some referrals are
20 conditioned on the number of stars that
21 someone has in terms of the Medicare ratings?

22 MS. BROWN: Yes.

23 There was one of our referral letters
24 that did state that we needed to meet that

1 criteria once we had skilled care up and
2 going. With our history at Lutheran Life
3 Communities, this has to go with the ACO on
4 readmission rate and that.

5 Within our current Illinois communities
6 right now, like I mentioned earlier, they are
7 all four- and five-star communities. We don't
8 anticipate to be any less than that, knowing
9 the resource and what we bring to the table as
10 far as our history and all the different
11 components of the care needs.

12 On top of that, currently we're running
13 around -- I believe it's a 12.8 percent
14 readmission rate with our Illinois communities
15 as well. The national average right now, I
16 believe, is close to 17. So we are below
17 that.

18 So we feel we will be able to respond to
19 that, but, yes, that was one of the criteria
20 we need to meet.

21 CHAIRPERSON OLSON: Just to
22 piggyback on that, I don't think we can
23 underemphasize that. I don't live in
24 Bloomington. I have an elderly parent. If I

1 was shopping for a nursing home for an elderly
2 parent, what do I have to go on but the
3 Medicare rating? It's not very good in this
4 area.

5 I mean, I worked in nursing homes for
6 ten years. I understand you can have a bad
7 rating. But you know what? Then you need to
8 get your rating up. The report that just came
9 out yesterday, Illinois is the worst in the
10 nation for nursing homes.

11 If I'm moving my mom somewhere, I want
12 the option of a four- or five-star nursing
13 home. I don't have that right now. That's my
14 opinion.

15 Other questions or comments?

16 MR. CARVALHO: I forgot. There was
17 one other point I wanted to make, and that's
18 the discussion about the impact on other
19 homes.

20 I certainly often said that our job here
21 is not to protect the financial bottom line of
22 other homes, but it is to protect the
23 infrastructure of the health care facilities
24 in the region since by definition under the

1 Certificate of Need process, we cap the amount
2 of facilities.

3 So if we are capping the amount of
4 facilities, it's important that the facilities
5 that are there thrive or that we don't do
6 something that, by making exceptions to our
7 rules, undermines them.

8 So the point that I think was missed in
9 some of your responses to some of Mr. Penn's
10 questions is it's not only the impact that
11 your pulling persons from other homes would
12 have, but it's who or the payer source that
13 you'll be pulling from other homes.

14 The analogy which we are much more
15 familiar seeing is in the hospital environment
16 where we worry as a Board that ASTCs, surgical
17 treatment centers, are pulling the highly
18 insured, the higher-paying patients away from
19 hospitals, undermining the financial mix of
20 the hospital where the hospital is able to be
21 financially viable because it has that mix of
22 private pay and private insurance and Medicare
23 and Medicaid.

24 If you do something that undermines the

1 part of its payer mix that is private
2 insurance, it's more dependent on Medicare and
3 Medicaid, and that makes it less financially
4 viable.

5 I think the concern Mr. Penn was
6 discussing -- and I'm not sure he fully
7 impressed -- was, yes, the total number of
8 patients that you may pull from other homes to
9 you will look small, but aren't you likely to
10 be pulling the better reimbursed patients that
11 thereby undermine the financing of some of the
12 other homes?

13 MS. BROWN: We fully plan to be not
14 just Medicare certified but also Medicaid as
15 well.

16 So to answer that question, we would
17 be -- I mean, I don't know that I can answer
18 what payer sources, but we fully plan to have
19 a mix of private pay, Medicare, and Medicaid.

20 MR. CARVALHO: If you are building
21 more the private homes since they are not
22 otherwise available in this market, aren't you
23 going to fill up with -- you may be certified
24 to have patients in all those categories, but

1 aren't you likely to -- in the health care
2 arena we refer to it as skimming.

3 Aren't you likely to be skimming from
4 other nursing homes?

5 MS. BROWN: No.

6 I mean, being not-for-profit, you know,
7 our mission is about serving seniors, and we
8 are not -- while we need to be economically
9 feasible, this is not about making a profit.

10 Our other communities, some of them run
11 a 50 percent Medicaid population because, you
12 know, we actually have funding through other
13 means in our organization to assist us with
14 being able to provide that service. We
15 recognize it's a need, and we want to be part
16 of meeting that need.

17 MR. HOLBROOK: I think the other
18 point there is that as a faith-based
19 organization, we do have the ability to raise
20 money for benevolent care, and we've been able
21 to do that.

22 We've kept our promise to our residents
23 that if someone runs out of funds, they will
24 never move out of a Lutheran Life community.

13-018 - LUTHER OAKS, INC.

175

1 That's our commitment to them. That's what
2 they bought into. So that's our commitment to
3 our residents at all times.

4 MEMBER BRADLEY: Isn't that kind of
5 how the State Medicaid program works anyway?

6 MR. HOLBROOK: Repeat the question,
7 please.

8 MEMBER BRADLEY: If you run out of
9 money, don't you go on Medicaid?

10 MR. HOLBROOK: Yes, you do.

11 MEMBER BRADLEY: Isn't the nursing
12 home supposed to keep you?

13 MR. HOLBROOK: They are supposed
14 to, but they don't always.

15 There is not always a bed available for
16 someone that runs out of funds. There are
17 limited beds and limited facilities in our
18 experience.

19 So when that person does run out of
20 funds and there's not a bed available, guess
21 who gets a call? Sometimes it's been us.

22 So from that perspective, nobody leaves
23 a Lutheran Life community, no matter what
24 level of care they are in. That's our

13-018 - LUTHER OAKS, INC.

176

1 commitment to our residents.

2 CHAIRMAN OLSON: Other questions or
3 comments?

4 I would entertain a motion at this time
5 to approve Project 13-018, Luther Oaks, Inc.,
6 to establish a 36-bed long-term care facility
7 in Bloomington, Illinois.

8 May I have a motion, please?

9 MEMBER BURDEN: So move.

10 CHAIRPERSON OLSON: Second?

11 I'll second the motion.

12 Roll call, please?

13 MR. ROATE: Motion made by
14 Dr. Burden, seconded by Chairwoman Olson.

15 Mr. Bradley.

16 MEMBER BRADLEY: I believe that
17 this project, based on the State Agency
18 Report, does not meet at least two criteria,
19 service accessibility and unnecessary
20 duplication, which I consider to be
21 significant factors.

22 Because of that, I vote no.

23 MR. ROATE: Thank you.

24 Dr. Burden.

1 MEMBER BURDEN: I, of course, have
2 noted that the service accessibility and
3 unnecessary duplication are listed in the
4 State Board Standards not met.

5 Also, I believe it is a problem that the
6 Luther Oaks project application will lower
7 utilization of other facilities.

8 So on that basis, I vote no.

9 MR. ROATE: Thank you.
10 Senator Demuzio.

11 MEMBER DEMUZIO: Based on the
12 unnecessary duplication of services, I vote
13 no.

14 MR. ROATE: Justice Greiman.

15 MEMBER GREIMAN: I am intrigued by
16 the fact that it's obvious that the Board
17 members have a positive attitude towards these
18 people, and yet we're stuck with the rules
19 that we have established.

20 Recently, as in the case before, we use
21 a rule to deny rights; and now we're faced
22 with another rule, which essentially has some
23 more problems.

24 My question was: What is it that will

1 take us out of that? And the faith aspect of
2 it isn't quite enough.

3 So with some broken heart, I have to
4 vote no.

5 MR. ROATE: Ms. Olson.

6 CHAIRPERSON OLSON: I'm actually
7 going to vote yes for this project. I do
8 believe that the criteria met outweigh the
9 criteria not met.

10 I also believe that access to care means
11 access for everybody, not just people who do
12 not have money. As somebody who works every
13 day in a health care center, I certainly see
14 the other end; but I also believe that people
15 who do have money deserve access to care.

16 So I vote yes.

17 MR. ROATE: Mr. Penn.

18 MEMBER PENN: I do appreciate
19 trying to bring new jobs to the
20 Bloomington-Normal area. I wish it was just
21 that simple; but because of the duplication of
22 services, I will vote no.

23 MR. ROATE: Thank you.

24

**13-026 - ADVOCATE LUTHERAN
GENERAL HOSPITAL**

179

1 Mr. Sewell.

2 MEMBER SEWELL: I vote no for the
3 reasons stated.

4 MR. ROATE: Thank you, sir.

5 That's six votes in the negative, one
6 vote in the affirmative.

7 CHAIRPERSON OLSON: Motion fails.

8 MR. URSO: You will be receiving a
9 Certificate of Denial and also some additional
10 information.

11 Thank you.

12 MR. HOLBROOK: Thank you.

13 CHAIRPERSON OLSON: Okay. The next
14 project is 13-026, Advocate Lutheran General
15 Hospital.

16 Mr. Constantino, State Agency Report?

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

19 The applicants are proposing to
20 modernize a Level I Trauma Center/Emergency
21 Department, the Surgery Center, PACU, and add
22 eight observation beds. In addition, a new
23 loading dock, a materials management support
24 function, and mechanical upgrades will be

**13-026 - ADVOCATE LUTHERAN
GENERAL HOSPITAL**

180

1 modernized.

2 The estimated cost of the project is
3 approximately \$39.7 million. The anticipated
4 project completion date is September 30, 2016.
5 There was no opposition, and no public hearing
6 was requested.

7 Thank you, Madam Chairwoman.

8 CHAIRPERSON OLSON: Thank you.

9 If the gentlemen at the table would
10 introduce themselves and be sworn in, please.

11 MR. NELSON: Scott Nelson, Director
12 of Planning and Design for Advocate Health
13 Care.

14 MR. OURTH: Joe Ourth, Arnstein &
15 Lehr, Legal Counsel.

16 MR. ARMADA: Anthony Armada,
17 A-r-m-a-d-a, President of Advocate Lutheran
18 General Hospital.

19 DR. PROPP: Dr. Douglas Propp,
20 Chairman of Emergency Medicine, P-r-o-p-p.

21 MR. SO: Jeff So, S-o, Director of
22 Business Development, Advocate Health Care.

23 (The witnesses were thereupon
24 duly sworn.)

**13-026 - ADVOCATE LUTHERAN
GENERAL HOSPITAL**

181

1 CHAIRPERSON OLSON: Questions,
2 comments for the Board?

3 MR. ARMADA: Good afternoon,
4 members of the Board. My name is Tony Armada.
5 I'm privileged to serve as the President of
6 Advocate Lutheran General Hospital.

7 With me today, as you heard, is Jeffrey
8 So, who is Director of Business Development at
9 Advocate Health Care; Scott Nelson, our
10 Director of Design and Construction; and Joe
11 Ourth, our CON counsel. Other representatives
12 are in the audience.

13 We are very pleased today to have with
14 us Dr. Douglas Propp. Dr. Propp has been the
15 Medical Director and Chairman for our
16 Emergency Department since 1992.

17 He's also Professor of Emergency
18 Medicine at Chicago Medical School, a
19 distinguished researcher and author of many
20 articles and publications.

21 He is the past president of the Illinois
22 Chapter of the American College of Emergency
23 Physicians and currently serves as an examiner
24 for the American Board of Emergency Medicine.

**13-026 - ADVOCATE LUTHERAN
GENERAL HOSPITAL**

182

1 Advocate Lutheran General Hospital is a
2 very unique place that serves as a referral
3 destination for numerous services and
4 specialties.

5 We are proud of being a high-reliability
6 and high-performance organization with a
7 strong focus on safety and quality, service
8 excellence, and satisfaction for those we have
9 the privilege to render health care to and
10 serve.

11 We are also equally proud of the many
12 partnerships that we have with the communities
13 we serve, in particular becoming an EMS System
14 Resource Hospital for Region 9 in 2012.

15 The EMS team is responsible for the
16 prehospital patient care delivered by five
17 local fire departments, including ongoing
18 education, skill verification, and the
19 development of a paramedic training program.

20 We are also the only Level I trauma
21 center that acts as a referral destination for
22 higher level of care from the surrounding 11
23 Level II trauma centers.

24 Our application that is before you today

**13-026 - ADVOCATE LUTHERAN
GENERAL HOSPITAL**

183

1 includes the expansion of two of our highest
2 acuity services, our Level I Trauma Emergency
3 Department, which will be addressed by
4 Dr. Propp, and our Advanced Surgical Services
5 Institute.

6 Our Surgical Department specializes in
7 complex surgeries in disciplines including
8 orthopedics and spine, cardiovascular surgery,
9 neurosurgery, and cancer surgery. We are also
10 the leaders in minimally invasive and robotic
11 surgery.

12 There is only one negative finding in
13 the State Agency Report, and that relates to
14 the number of projected trauma rooms and
15 emergency stations that we are requesting.

16 I'd like to make note that your Staff
17 found these projections reasonable and
18 attainable. Dr. Propp will further address
19 the need to expand emergency services at the
20 hospital.

21 Thank you for your time and
22 consideration of our project today.

23 CHAIRPERSON OLSON: Thank you.

24 DR. PROPP: I appreciate the

**13-026 - ADVOCATE LUTHERAN
GENERAL HOSPITAL**

184

1 ability to represent as many skilled
2 clinicians in our facility, both the 27
3 emergency physicians, over 80 nurses, and
4 other technicians and folks who staff the
5 Emergency Department and are allowed to
6 function at a very high level based on the
7 facility we currently have and one we hope to
8 expand.

9 As Mr. Armada said, we are a
10 comprehensive Emergency Department and Level I
11 trauma center. Only 8 percent of Emergency
12 Departments are Level I trauma centers, and 11
13 Level IIs refer to us from McHenry -- up north
14 from McHenry, west from Aurora, from the
15 northern portion of Chicago and all the way to
16 94 East.

17 We are also recognized by the Illinois
18 Department of Emergency Services for Children
19 as an Emergency Department appropriate for
20 pediatrics, providing specialized care, having
21 the right facilities to care for sick and
22 injured children.

23 We're a primary stroke center where we
24 not only take care of stroke patients

**13-026 - ADVOCATE LUTHERAN
GENERAL HOSPITAL**

185

1 administering clot-busting drugs, but we also
2 receive many patients from other referral
3 hospitals to do that kind of care, including
4 interventional radiology for patients who may
5 benefit from that and aggressive and
6 appropriate therapy.

7 As Mr. Armada said, we are a resource
8 hospital for five community paramedic training
9 programs, and we also partner with the
10 University of Illinois Emergency Medicine
11 Residency Program training the next generation
12 of emergency physicians.

13 Emergency departments continue to see a
14 rise in the population of patients needing our
15 attention. Lutheran General is no exception.
16 We have an aging population and surrounding
17 demographics with increased utilization.

18 Overall, the utilization of emergency
19 departments is over 30 percent. When you look
20 at the elder population, it's higher than
21 that, much closer to 50 percent.

22 We obviously provide 24/7 access to all
23 in need of care, and folks come to the
24 Emergency Department frequently as lay people

**13-026 - ADVOCATE LUTHERAN
GENERAL HOSPITAL**

186

1 with symptoms, not knowing that their chest
2 pain may or may not be a heart attack, and
3 we need to be able to tell them "Yes, you have a
4 problem" or "No, it's nothing significant."

5 We have a lack of primary care
6 physicians in our community, like other
7 communities, who cannot take care of all the
8 patients who need attention.

9 We are particularly seeing increased
10 numbers of patients with addictions and
11 behavioral health issues where the community
12 infrastructure is not able to accommodate
13 those patients, and we are there 24/7 for
14 them.

15 Finally, we're anticipating with the
16 Affordable Care Act that the utilization of
17 the emergency departments will increase and
18 not in fact decrease.

19 The nuances of emergency care from a
20 clinical perspective have changed dramatically
21 over the last several years where timely care
22 within an hour is mandatory for more and more
23 clinical conditions based on ongoing research.

24 For example, the 70-year-old female who

**13-026 - ADVOCATE LUTHERAN
GENERAL HOSPITAL**

187

1 has bacteria growing in her blood from a prior
2 urinary tract infection needs to be
3 acknowledged, diagnosed, resuscitated
4 appropriately with fluids, and have
5 antibiotics started emergently.

6 The 35-year-old male who is having chest
7 pain related to a heart attack needs to be
8 identified, taken to the catheterization lab,
9 and have the culprit vessel opened and stented
10 in a timely fashion.

11 The 60-year-old nurse who is transferred
12 from another stroke center having a
13 life-threatening problem where we can
14 hopefully intervene and bring that person back
15 to their normal daily activities is something
16 that we can do, given the facilities that we
17 have.

18 As a Level I trauma center, we are the
19 golden hour of opportunity to reverse some of
20 the potentially irreversible injuries
21 sustained from blunt and some penetrating
22 trauma we see.

23 This is in addition to all the other
24 typical problems we see as a high-intensity

**13-026 - ADVOCATE LUTHERAN
GENERAL HOSPITAL**

188

1 Emergency Department related to children with
2 fever, lacerations, fractures, abdominal pain,
3 headache, and I can continue.

4 Our current space has 30 beds and three
5 resuscitation suites, which truly are not
6 enough space, and it ends up being the rate
7 limiting step for us to see patients in a
8 timely fashion and not have them wait.

9 Unfortunately, the waits that we are
10 seeing for patients coming to our facility in
11 order to see a physician are not short enough,
12 and we're trying to impact that.

13 In addition, in order to see patients in
14 a timely fashion, we have to see patients in
15 hallways where there is lack of privacy and
16 just basic human dignity.

17 Our current space was constructed over a
18 decade ago, and we currently have 472 square
19 feet per bed, which the State guidelines are
20 twice that size.

21 The new space we're asking for has seven
22 more rooms, seamless connection with the
23 current physical plant, additional pediatric
24 space, and additional support space.

**13-026 - ADVOCATE LUTHERAN
GENERAL HOSPITAL**

189

1 We used two methodologies to project the
2 need for more Emergency Department rooms, both
3 developed by the American College of Emergency
4 Physicians.

5 The first is based on the total number
6 of patients seen in the department every hour
7 of the day. This methodology justified the
8 need for at least 45 rooms by 2018.

9 The second method examined a range of
10 operational indicators that affect the need
11 for treatment rooms. Again, more than 45
12 treatment rooms were justified.

13 We are being conservative in requesting
14 only 37 Emergency Department rooms with our
15 current three resuscitation rooms, five fewer
16 than can be justified. The Agency's Staff has
17 reviewed our projections and believes they are
18 reasonable and attainable.

19 The State Agency only has one guideline
20 for measuring the need for Emergency
21 Departments, but in the case of emergency
22 services, one size does not fit all.

23 According to the American College of
24 Emergency Physicians, a department with our

**13-026 - ADVOCATE LUTHERAN
GENERAL HOSPITAL**

190

1 volume serving very high-acuity patients
2 should be planned for 1,800 visits per bed per
3 year. The proposed 40 rooms we are requesting
4 will be operating at 1,892 visits per room,
5 higher than the ACEP guideline or 93 percent
6 of the State Agency's guideline after the
7 expanded unit opens.

8 The enlarged Emergency Department will
9 have the right number of appropriately sized
10 rooms as well as the necessary support spaces
11 in a configuration that enables optimal staff
12 communication, efficient workflow, and an
13 appropriately reassuring environment
14 reflective of our clinicians.

15 There has been no opposition to our
16 project. We have community support, as
17 demonstrated by letters included in our
18 application and on the Web site.

19 As the community resource which is open
20 24/7, staffed with exceptional clinicians, has
21 an excellent medical staff backup, is the
22 "go to" hospital for many other institutions,
23 and willing to see all who arrive regardless
24 of their ability to pay, I ask you to vote

**13-026 - ADVOCATE LUTHERAN
GENERAL HOSPITAL**

191

1 positively in support of our proposal.

2 Thank you very much.

3 CHAIRPERSON OLSON: Thank you,
4 Doctor.

5 Questions from the Board?

6 I actually have a clarification for
7 Mr. Constantino.

8 Based on what the Doctor just shared
9 with us, the projection that their methodology
10 came out to 2018, that's why you made the
11 statement on Page 3 that "The State Board
12 Staff's review of these projections leads us
13 to believe that they are reasonable and
14 attainable."

15 So we do believe that by 2018, they will
16 be able to reach capacity for the 40 beds?

17 MR. CONSTANTINO: What I looked at
18 was prior information that has been provided
19 to us on their profile information for the
20 last five or six years. It appeared to me
21 that there was a growth of 10 to 12 percent
22 per year.

23 When I projected that out, it appears to
24 me that if that continues, they will be able

**13-026 - ADVOCATE LUTHERAN
GENERAL HOSPITAL**

192

1 to achieve the number -- they will need the
2 number of rooms they are requesting.

3 Our rules require only that -- we're
4 negative on this report because we had to look
5 at their current utilization. Their current
6 utilization does not justify the number of
7 rooms being requested. So you have two
8 different things there.

9 When I looked at their methodology and I
10 looked at what they had provided to us
11 previously, it showed a growth pattern of
12 10 to 12 percent per year in their Emergency
13 Department. That's the information they
14 provided on their profile information.

15 CHAIRPERSON OLSON: Thank you. I
16 appreciate that.

17 Just a couple more questions.

18 Doctor, you alluded to your average wait
19 time. What is your average wait time right
20 now?

21 DR. PROPP: The latest wait time is
22 approximately one hour, which is not
23 acceptable, although compared to other
24 facilities in the country, it's pretty good,

**13-026 - ADVOCATE LUTHERAN
GENERAL HOSPITAL**

193

1 but it's not acceptable for our patient
2 population.

3 CHAIRPERSON OLSON: I also wondered
4 if you run into the issue -- I know you said
5 that you do take mentally ill patients.

6 Do you run into the issue of mentally
7 ill patients being held up in the Emergency
8 Department waiting for a bed somewhere else,
9 so that's going to tie up one of your rooms
10 while you're waiting for a disposition for
11 those patients?

12 DR. PROPP: Absolutely correct.

13 We have eight to ten patients on average
14 per day waiting for treatment for addiction or
15 psychological problems.

16 CHAIRPERSON OLSON: Sometimes, I
17 understand from other facilities, a day, two
18 days. A long time?

19 DR. PROPP: Several days.

20 CHAIRPERSON OLSON: Thank you.

21 Other questions or comments from Board
22 members?

23 MR. CARVALHO: Just one question.

24 You said something that I just wanted

**13-026 - ADVOCATE LUTHERAN
GENERAL HOSPITAL**

194

1 you to clarify because, otherwise, it will
2 become something that the next 20 applicants
3 all say, too. So clarify what you mean.

4 You said that with the implementation of
5 the Affordable Care Act, you expect to see
6 more traffic in the emergency room.

7 Could you put a time frame on that?

8 DR. PROPP: I'm not sure what you
9 mean by "a time frame," but the experience, at
10 least in Massachusetts, and projections from
11 many people in emergency medicine circles who
12 are knowledgeable is that with the added
13 insurance coverage and the lack of primary
14 care capacity in the community, many more
15 patients will be seeking primary care services
16 from Emergency Departments like ours.

17 MR. CARVALHO: Then I guess I do
18 want to elaborate on that a little bit.

19 I have no doubt that that's true in the
20 short run. The whole apparatus of the
21 Affordable Care Act, the State's efforts under
22 the Affordable Care Act, everybody who wants
23 to see the Affordable Care Act succeed saw
24 that not be true in the medium run or the long

**13-026 - ADVOCATE LUTHERAN
GENERAL HOSPITAL**

195

1 run. So for purposes of your project, I don't
2 think you need to assume that to be true.

3 I'm not trying to undermine the support
4 for your project, which I think is
5 substantial; but I don't want it to become
6 part of the currency of the conversation
7 before this Board that because the Affordable
8 Care Act is coming, everybody needs a bigger
9 emergency room because that's an awful lot of
10 construction for a problem that we as a
11 society hope to deal with in a much more cost
12 effective and appropriate way.

13 It happens to be happening while we're
14 happening to be needing this project for other
15 reasons, but it is not and should not be part
16 of our planning that we need to change our
17 standards for emergency rooms and let
18 everybody build bigger and more emergency
19 rooms because that's what the Affordable Care
20 Act will require and we'll see in the long
21 run.

22 CHAIRPERSON OLSON: I would submit
23 that everyone in this room can agree that we
24 have no idea what's going to happen. We'll go

**13-026 - ADVOCATE LUTHERAN
GENERAL HOSPITAL**

196

1 on that assumption.

2 Questions? Comments?

3 May I have a motion to approve Project
4 13-026, Advocate Lutheran General Hospital to
5 expand Emergency and Surgery Departments? May
6 I have a motion?

7 MEMBER DEMUZIO: Motion.

8 MEMBER PENN: Second.

9 MR. ROATE: Motion made by Senator
10 Demuzio, seconded by Mr. Penn.

11 CHAIRPERSON OLSON: Roll call,
12 please?

13 MR. ROATE: Mr. Bradley.

14 MEMBER BRADLEY: This proposal
15 meets nine criteria completely, and I think
16 the discussion about the growth rates that
17 they have experienced negates the doubts
18 raised by the tenth criteria.

19 So I think this project certainly should
20 go forward, and I vote yes.

21 MR. ROATE: Thank you, sir.

22 Dr. Burden.

23 MEMBER BURDEN: Yes.

24 MR. ROATE: Senator Demuzio.

**13-026 - ADVOCATE LUTHERAN
GENERAL HOSPITAL**

197

1 MEMBER DEMUZIO: Yes.

2 MR. ROATE: Justice Greiman.

3 MEMBER GREIMAN: My only concern is
4 that you're making the whole Park Ridge Place
5 bigger. Right now it takes an hour if I want
6 to go visit somebody just to find out where to
7 go, but I'm going to vote yes anyhow.

8 MR. ROATE: Thank you.

9 Ms. Olson.

10 CHAIRPERSON OLSON: I vote yes as
11 well.

12 I agree with Mr. Bradley that the one
13 negative finding was explained quite well by
14 the applicant and is certainly not a concern.
15 So I vote yes for that reason.

16 MR. ROATE: Thank you.

17 Mr. Penn.

18 MEMBER PENN: I'm going to vote
19 yes.

20 MR. ROATE: Mr. Sewell.

21 MEMBER SEWELL: Yes.

22 MR. ROATE: That's seven votes in
23 the affirmative.

24 CHAIRPERSON OLSON: Okay.

1 Congratulations, gentlemen.

2 The Motion passes.

3 Moving along, next we have Project
4 13-025, University of Chicago Medical Center.

5 Do you need a break? Ten minutes. I'm
6 sorry. Ten-minute break.

7 (Whereupon, a recess was had
8 at 2:45 p.m., after which the
9 proceedings were resumed at
10 2:55 as follows:)

11 CHAIRPERSON OLSON: We are back in
12 session.

13 13-025, University of Chicago Medical
14 Center. We have the applicant at the table.

15 Mr. Constantino, Staff Report, please?

16 MR. CONSTANTINO: Thank you, Madam
17 Chairwoman.

18 The applicant proposes to add 38 medical
19 surgical beds for a total of 338 medical
20 surgical beds at the University of Chicago
21 Medical Center.

22 The estimated cost of this project is
23 approximately \$3.4 million. The anticipated
24 project completion date is September 30, 2014.

1 There was no opposition. And no public
2 hearing was requested.

3 Thank you, Madam Chairwoman.

4 CHAIRPERSON OLSON: Thank you,
5 Mr. Constantino.

6 If the applicants would introduce
7 themselves, spell your name, and be sworn in,
8 please.

9 MS. O'KEEFE: Thank you, Madam
10 Chair. I'm Sharon O'Keefe, and I'm the
11 President of the University of Chicago Medical
12 Center. That's O-K-e-e-f-e.

13 I am joined here today by Dr. Stephen
14 Weber, W-e-b-e-r, our Chief Medical Officer;
15 Deborah Albert, A-l-b-e-r-t, our Chief Nursing
16 Executive; John Beberman, B-e-b-e-r-m-a-n, our
17 Director of Capital Planning; and Joe Ourth,
18 O-u-r-t-h, our CEO and Legal Counsel.

19 It's a privilege to be here. Thank you
20 for the opportunity.

21 (The witnesses were thereupon
22 duly sworn.)

23 CHAIRPERSON OLSON: Comments for
24 the Board?

1 MS. O'KEEFE: Yes. Thank you very
2 much.

3 We are here to ask approval to reopen 38
4 existing medical surgical beds that we
5 actually had recently decommissioned as part
6 of our new hospital opening. Our new hospital
7 opened in February of 2013, and it is called
8 The Center for Care and Discovery.

9 We are seeking to alleviate a critical
10 capacity constraint at our facility. Within
11 the recent past, we have had a significant
12 growth in our activity at the medical center;
13 and with a modest investment, of \$3.4 million,
14 we can immediately and quickly make beds
15 operational and relieve this constraint.

16 Five years ago we were here, not that
17 long ago, when we undertook the CCE project,
18 and at that time we forecasted a growth rate
19 of 1.2 percent in our activity level. At that
20 time we voluntarily decreased our med/surg bed
21 base from 327 down to 300.

22 Since then, actually, our utilization
23 has grown in the recent past by 4.3 percent.
24 This is actually consistent with a renewed

1 focus on improving access to our facility,
2 both in the Emergency Department, opening up
3 our facility to interhospital transfers, and
4 actively managing our bed base in a more
5 proactive manner.

6 We are pleased that the State Agency
7 Report found that our application complied
8 with 12 of the 13 criteria. The sole negative
9 finding was that the historical utilization
10 appears to not justify that all of the beds
11 will operate at the 90 percent occupancy
12 level.

13 This regulatory standard actually
14 calculates an average utilization using the
15 Midnight Census. The Midnight Census is
16 particularly challenging for any acute care
17 hospital and particularly for one with a busy
18 Emergency Department and a high volume of
19 interhospital transfers.

20 Volume does not arrive at our
21 institution in a predictable or an orderly
22 manner on a daily basis, weekly, monthly, or
23 even throughout the year.

24 For this reason, we not only track the

1 Midnight Census, which is a good benchmark for
2 the day, but we also monitor our census every
3 six hours looking for periods of peak
4 utilization of our bed base. This examination
5 every six hours allows us to plan better for
6 the demands of access to our institution.

7 This peak load analysis that we have
8 conducted and have examined over the past year
9 identified a number of interesting trends.

10 When we look back at 2012, this analysis
11 demonstrated that 35 percent of the days we
12 actually operated at greater than 90 percent
13 occupancy. So one out of three days we were
14 operating at peak census or above 90 percent.

15 When we look forward into our current
16 calendar year 2013, January through March,
17 this rate of 90 percent or greater occupancy
18 increased to 44 percent of our days. Again,
19 April through June, actually 56 percent of our
20 days operated above the 90 percent activity
21 level.

22 Interesting enough, in July, which we
23 just closed out, which is a month that
24 generally is a little bit of a lighter census,

1 we performed at 61 percent of the days above
2 the 90 percent occupancy level.

3 Exceeding the optimal occupancy level on
4 a recurrent basis such as this creates real
5 consequences for our community and for the
6 patients we serve.

7 It impacts our Emergency Department
8 performance in a very negative way, both in
9 terms of diversion, left-without-being-seen
10 rates, and overall length of stay in our
11 emergency room, and on a frequent basis it
12 does not allow us to take in high-acuity
13 transfers from other community hospitals in
14 our region.

15 In summary, I believe that the
16 operational need of this project is evident
17 from our peak load analysis, which
18 demonstrates a clear upward trend in
19 utilization at levels that we cannot sustain
20 going forward.

21 In our application we have also
22 demonstrated that our continued growth of
23 4.3 percent per year and having the capacity
24 to serve the current but unmet demand that

1 we've documented, we will actually reach the
2 regulatory requirement of 90 percent targeted
3 occupancy within the next two years.

4 You will also see from support letters
5 from the City's Fire Department and the EMS
6 directors that there is a need for continued
7 work on alleviating and minimizing diversion
8 in our emergency room.

9 The need is also apparent in that you
10 see no opposition to this project. So we are
11 undertaking this project to better meet the
12 needs of the patients in our community that we
13 serve, and we ask your full consideration for
14 approval of this project.

15 Thank you.

16 CHAIRPERSON OLSON: Thank you.

17 Questions by Board members?

18 MR. CARVALHO: I mentioned to
19 representatives from the applicant that I
20 would have some questions on the bypass
21 information since the substantial reason
22 proffered for the need for the bed relates to
23 bypass.

24 I did pull the information together so

1 it would be handy. I'd like to share it with
2 the Board, too. I forgot to hand this out at
3 the break.

4 MEMBER GREIMAN: I have one.

5 CHAIRPERSON OLSON: Yes, Justice?

6 MEMBER GREIMAN: This is not
7 exactly direct, but I asked this before to a
8 hospital.

9 You have a very good record based on the
10 numbers of charity care, except isn't there a
11 difference in the percentage -- in the way you
12 figure the charity care?

13 For example, you have up in med care or
14 the insurance thing, you charge \$1,000. They
15 pay \$500. You say, "Fine. Very good."

16 But Medicare -- or the poverty, your
17 charity, you say, "Well, we charge \$1,000. We
18 charge \$1,000."

19 So in one you have just the charges and
20 not the reality of it, and then in the other
21 one you have the reality.

22 So doesn't that make a difference in the
23 percentage so your percentage really isn't
24 honest? I'm not saying you want to be

1 dishonest, but the percentage isn't honest for
2 that reason.

3 Did I make myself clear? I tried to.

4 MR. CARVALHO: Madam Chair, since
5 we compiled a questionnaire that we asked the
6 hospitals to fill out, maybe I should jump in
7 and explain it because the applicant looks a
8 little puzzled.

9 I know exactly what you're getting at,
10 Justice Greiman.

11 When we asked applicants to fill out the
12 questionnaire, we recognized that it would be
13 inappropriate to count the charity care based
14 on charges because charges has nothing to do
15 with what anybody pays, whether it be
16 commercial insurance, Medicaid, Medicare.

17 So to count the charity care based on
18 charges would be to inflate the charity care
19 numbers way beyond what is appropriate.

20 So what applicants do is for everybody
21 who doesn't pay them, they tally up what they
22 actually get. That's their revenues. So
23 every other payroll what they're getting paid
24 is based on reality, not charges, what they're

1 actually getting paid.

2 For charity care, what they do is they
3 start with charges, but then they apply what
4 Medicaid agencies and Medicare agencies call
5 the cost-to-charges ratio.

6 For purposes of an official filing with
7 the Federal Government, so we know there's
8 consequences to the fibbing, the hospitals
9 keep track of what the costs are and what
10 their charges are, and then there's a
11 percentage. So you can imagine that for some
12 places it might be 65 percent. The cost is
13 only 65 percent of charges. In other places
14 it might be higher; it might be lower.

15 But that's the number that they have
16 sworn to the Federal Government is the
17 percentage of --

18 MEMBER GREIMAN: So then the
19 figures on our charts reflect that; is that
20 right?

21 MR. CARVALHO: Yes.

22 We tell them to take the charges,
23 multiply by the cost-to-charges ratio. So as
24 you can tell from the description, it's a

1 little bit better than the back of the
2 envelope because clearly the cost of some
3 procedures is different than the cost of
4 others compared to charges.

5 But by and large, all of the numbers for
6 charity care are scaled down to cost using the
7 cost-to-charges ratio.

8 MEMBER GREIMAN: I guess I should
9 have asked our Staff instead of you. Thank
10 you for the answer.

11 CHAIRPERSON OLSON: Okay.
12 Mr. Carvalho, do you want to continue?

13 MR. CARVALHO: I handed out a
14 chart.

15 What I've done, in your State Agency
16 Report you had some of this information about
17 the beds that are authorized. Keep in mind
18 these are the authorized beds.

19 So in this chart, this is for University
20 of Chicago. You can tell I did the
21 spreadsheet myself because it's not pretty and
22 it's not labeled. It should say at the top
23 "University of Chicago," but it doesn't.

24 So under each year, the first column is

1 the authorized beds, and the second column is
2 the percentage of utilization based on
3 authorized beds.

4 That's something that we get from the
5 hospitals and Mr. Constantino often includes
6 in your report. I think there is somewhere in
7 there that has some of these numbers, in fact.

8 So the top box is their beds and the
9 utilization as reported to us by the hospitals
10 for each year through 2011. I included 2012.
11 That's what they reported to us.

12 We haven't published it yet; but since
13 it came from them, I knew it would not be
14 surprising to them. Those are the 2012
15 numbers.

16 The two caveats from the asterisk that
17 you should note are that you'll see that the
18 medical surgical beds went from 327 to 300 in
19 2008.

20 That's because once you approved an
21 application -- and you did approve the
22 application to reduce those number of beds for
23 the new hospital -- for purposes of our
24 reports, we start showing 300; but, of course,

1 the new hospital wasn't open yet, so the old
2 hospital with 327 beds was still around. If
3 they wanted to use those beds, they could and
4 they probably did.

5 Then the flip side, which is the ability
6 symmetric, is in 2008 when you authorized
7 under Intensive Care the number of ICU beds to
8 go up from 92 to 114, theoretically they could
9 have started doing 114 beds right then.

10 For example, you'll notice in 2005 the
11 number was 127. If they had the space lying
12 around, then they could gear it up again; but
13 my understanding is they did not. In any
14 event, that's the two caveats in the table.

15 Then what I've juxtaposed it with is the
16 bypass numbers. We started collecting, "we"
17 being the Illinois Department of Public
18 Health, now on the Department of Public Health
19 side of the shop, started collecting this data
20 in an electronic format in the second part of
21 2007.

22 The reason why I put this together and
23 the reason why I wanted to go through a couple
24 questions is there are a couple of reasons

1 that the hospitals describe about why they
2 need the additional beds. One is to deal with
3 the bypass situation.

4 From what I've seen in the application
5 and what I've heard from them, it kind of
6 hangs together; but I'd really just like to
7 nail it all down. This has been a great
8 mystery to us, the Department, since 2007.

9 You know, it's like not since the
10 Yankees dominated baseball in the '40s and
11 '50s has someone led a hospital bed ranking
12 for so long and so consistently by so much.
13 We're not talking about a couple points here.

14 As you can see over this time frame, the
15 University of Chicago has been anywhere
16 between 22 and 30 percent on bypass. What
17 that means -- we keep track every hour. So if
18 there's 8,760 hours in a year, if your bypass
19 rate is 29 percent, it means 29 percent of
20 those 8,760 hours you were on bypass.

21 You can see that the average for all the
22 other hospitals in the State has generally
23 been about 1 percent, and the next highest
24 hospital -- it hasn't always been the same

1 hospital. It's varied, but the next highest
2 hospital in some years was only at 1 percent,
3 1 1/2 percent. In the very first year, it was
4 13.

5 So, you know, the question that occurred
6 to me -- and I think part of your application
7 explains it, and I want to make sure that the
8 applicant has an opportunity to explain it,
9 too -- is if beds alone were the issue, these
10 very high numbers for bypass were during the
11 period of time when they had the beds.

12 There's 327 beds authorized in '07, and
13 then they had authority to use 327 beds from
14 2008 to 2012 when the bypass numbers were all
15 very high. Ironically, we don't have the
16 numbers for 2013 because there was an interim
17 and we only ask for it once a year.

18 But the new hospital opened in 2013, so
19 the authority for beds did drop down now to
20 300, and the bypass rate is actually the
21 lowest it's been since we started recording.

22 So I understand from the narrative in
23 the application the tie-in between beds and
24 bypass, but something else has to be going on

1 other than beds. I wanted to make sure you
2 had an opportunity to explain what that
3 "something else" is.

4 It's nice to meet you. I wish I met you
5 prior to today. I know you weren't here until
6 two years ago. So you're, in a way, being
7 asked to describe what was going on when you
8 weren't here, but I'll nonetheless ask the
9 question.

10 MS. O'KEEFE: Thank you. I wish I
11 would have met you before, also.

12 I think that's actually a good point
13 because I won't try to go back, certainly not
14 to 2005 or through 2009.

15 I arrived at the Medical Center in
16 February of 2011. One of the first things
17 that became very apparent to me was that we
18 needed to improve both access to the
19 institution as well as operations of the
20 institution and specifically began focusing on
21 the Emergency Department.

22 Now, a couple of comments on diversion.
23 There are probably two different reasons why
24 we go on diversion. One is there is an

1 extraordinarily high influx of patients that
2 come into the emergency room and we are unable
3 to process them through the emergency room.
4 Some of those patients come and go and are
5 discharged home. Some end up being admitted.

6 We will go on bypass if we cannot handle
7 the volume of patients. So in order to reduce
8 this, we attacked kind of two things in the
9 emergency room.

10 One is the throughput patients who come
11 and go from the emergency room by expanding
12 our medical staff coverage and increasing our
13 ability to surge and to move patients through.
14 So we have significantly improved that
15 component of the emergency room operation.

16 The second component that puts us on
17 diversion is when we get an extraordinary high
18 level of patients waiting for an inpatient
19 bed. What happens at that point in time is we
20 lose sometimes a third, if not 50 percent, of
21 our operating capacity in the Emergency
22 Department. So bed access is the second
23 component of reducing our diversion rate in
24 the Emergency Department.

1 What we have been able to do since 2011
2 is to gain some ground on both of those. On
3 the bed base, what has helped us is moving
4 into the CCD, we went to 100 percent private
5 rooms.

6 So we gained what I would call a bit of
7 virtual capacity by being able to use every
8 bed, regardless of gender or infection control
9 issues, et cetera.

10 We are going to continue to work on the
11 diversion rate both through throughput of
12 patients as well as, hopefully, gaining a
13 little bit more in terms of our bed base so
14 that we can move patients out of the Emergency
15 Department as rapidly as possible when they
16 need access to a bed.

17 Right now that wait could be eight, ten,
18 or sometimes a greater number of hours, but we
19 are working diligently on diversion, and it
20 does relate to the bed base, not 100 percent,
21 but there is a strong correlation between
22 being able to access beds and our rate of
23 diversion.

24 MR. CARVALHO: If I could follow

1 up, also, I made myself some notes, and I
2 neglected to say a couple of things.

3 The first one that I wanted to say was
4 that our licensing program -- or not licensing
5 but the folks at the Department of Public
6 Health who regulate this function have been to
7 your institution several times and every time
8 have indicated that you are in compliance with
9 our rules.

10 So your being on diversion has never
11 been identified by the Department as being
12 something that you were doing out of
13 compliance with rules. I should have said
14 that at the very beginning.

15 In the application it talked -- and I
16 know you have been there for two years. I
17 don't know how many of the people at the table
18 who would be familiar with the topic predate
19 you. This may be not answerable.

20 But there was reference in the State
21 Agency Report, which presumably came out of
22 the application, that in the past there might
23 have been designation of beds for certain
24 services. I know that in the community that

1 sometimes has been talked about in terms of
2 holding beds for certain types of cases or
3 people were even making complaints that it was
4 holding beds for certain types of payers.

5 So I wanted to make sure you had an
6 opportunity to clarify what the reference to
7 designated beds for certain services was to;
8 and to clear up any of the hypotheses people
9 have had about the bypass situation, this
10 would be a good opportunity to do that.

11 MS. O'KEEFE: Great. All right.
12 I'll make some initial comments. Then
13 Dr. Weber could also make some comments.

14 As an academic medical center, there is
15 a history of having highly specialized beds.
16 So patients who have complex neurological
17 diseases or cancer diagnoses or
18 cardiovascular, they tended to go to
19 designated beds so that the teams of
20 clinicians could be matched effectively with
21 the individual patient needs.

22 When I mentioned arriving in 2011, in
23 addition to the Emergency Department, actively
24 managing our beds in a more proactive fashion

1 was something else that we began to focus on
2 and began to view our beds in a bit more of a
3 generic manner so that the entire bed base
4 could be available to patients on our surgical
5 services, interhospital transfers, as well as
6 patients coming out of our Emergency
7 Department.

8 So we began to take a much broader view
9 of our bed base and broke down some of those
10 what I call "specialty boundaries" with the
11 attempt of getting a patient to a bed at the
12 University of Chicago Medical Center as
13 quickly as possible.

14 I will ask Dr. Weber to make some
15 additional comments about the clinical needs
16 of patients and how we are meeting those
17 needs.

18 DR. WEBER: Thank you.

19 I would echo that perspective in this
20 transition that's happened over the last two
21 years now. It's a priority on access and
22 moving patients into the system irrespective
23 of their individual clinical needs, as it
24 were, but, again, getting them into a bed.

1 We do have, as I think many places like
2 us, some degree of constraint just in terms of
3 matching up the needs of the patients,
4 particularly to nursing expertise or
5 additional technology that might be in one
6 physical space or another.

7 But it really was -- for those of us who
8 have been in practice at the medical center
9 through this period, it really was a "see"
10 change for us in that patients were now
11 flowing through not on any basis according to
12 a specialty service or that but to come into a
13 bed.

14 We are having to remind people over the
15 last couple years that "A bed is a bed is a
16 bed, and our patients need to get in there."
17 I think that's really paid dividends in terms
18 of what you see by way of the bypass numbers
19 there.

20 I think that in general, for clinicians
21 at other area and more distant hospitals who
22 are seeking to transfer patients for more
23 highly specialized care, they are finding,
24 actually, they are able to move those

1 individuals in a faster and more efficient,
2 more satisfying patient center way than they
3 were previously.

4 So I acknowledge, I think, some of the
5 challenges that we had in the past and
6 certainly some of the perceptions that existed
7 about working from the inside. I think when
8 you talk with our community and our community
9 of referring providers, you'll see quite a
10 dramatic change now.

11 MR. CARVALHO: Thank you.

12 I think that is why I thought it was
13 important to have this conversation because
14 absolutely the changes have been remarkable in
15 terms of this year, the drop.

16 I have heard from many quarters that it
17 really is attributable to your leadership,
18 Ms. O'Keefe. I think that is very
19 commendable.

20 Some of the, again, discussion in the
21 past about why this was occurring was this
22 whole conversation about preserving beds for
23 certain categories, whether it be ostensibly
24 for medical reasons or financial reasons or

1 just internal political reasons.

2 If you've got a guy or a woman who is
3 producing a lot of patients in a particular
4 category and if they don't want to face the
5 situation where they can't schedule their
6 patients because they don't have a bed to put
7 them in, then you may -- not you, but in the
8 past they may want to reserves beds for a
9 particular reason to keep them.

10 The reason it's relevant to this Board
11 is if the Board is approving X number of beds,
12 they think they're all there to be used; and
13 if they're in fact being -- "Well, it looks
14 like you're giving us 300, but we're keeping
15 ten of them for that reason, for this reason,
16 that reason," they aren't in fact available.
17 For planning purposes, the Board really needs
18 to know that.

19 So the question -- and I think I know
20 the answer, but it's good to ask it. If you
21 get these beds back, I assume it is not your
22 intent to go back to the practices of the
23 past, that you have changed?

24 The other thing that gave me real pause,

1 there was a reference in there about patient
2 transfers that were lost. The patient
3 transfers that were lost have nothing to do
4 with the bypass issue. Those were transfers.

5 If these beds are to facilitate dealing
6 with not having to give up patients that were
7 proposed to be transferred, I wouldn't want to
8 see that have an adverse impact on the
9 positive things you've done in the bypass
10 because the Board authorized those beds for a
11 different purpose than bypass alleviation.
12 That's still beds for transfer patients.

13 MS. O'KEEFE: The incremental beds
14 will actually assist with both of those.

15 To give you a little bit better news, in
16 July, actually, our diversion rate was 8
17 percent. So it dropped again.

18 We are on a daily basis actively
19 managing the bed inventory. So these 38
20 incremental beds will go into our general
21 Med/Surg inventory to serve the needs of all
22 of the patients either through the Emergency
23 Department or through interhospital transfers.

24 I will say the demand for interhospital

1 transfers is significant and compelling to
2 transfer patients. Our case mix index on an
3 ongoing basis is about 1.89, and the community
4 hospitals that transfer us patients have a
5 case mix index closer to about 1.12 or 1.2.

6 So they are truly transferring patients
7 for a need of complex services that we offer
8 to the community, and we want to be open to
9 accept that patient population as well.

10 MR. CARVALHO: I hope I didn't
11 suggest from the question -- you are a
12 partner. You're a nationally recognized
13 place.

14 One of the points of the Affordable Care
15 Act is the right care at the right time at the
16 right place. You are the right place for that
17 kind of care. If it's good for you
18 financially or if it's bad for you
19 financially, that really isn't the issue.

20 But again, if the justification of beds
21 was in part to help you in bypass, I wanted to
22 make sure we nailed down what were really the
23 pitch points that were causing the bypass
24 problems and how the beds could help alleviate

1 since in the past you had a lot of beds and
2 you still had a lot of bypass.

3 It sounds like there have been internal
4 changes, but they have run their course in
5 terms of what they can contribute to deal with
6 the problem, and now the beds become a pitch
7 point.

8 So thank you very much. I hope this
9 wasn't grueling.

10 MS. O'KEEFE: Thank you.

11 CHAIRPERSON OLSON: We applaud your
12 efforts since 2011. It's so nice to have a
13 good woman in charge.

14 Any other questions or comments from the
15 Board?

16 Being none, I would entertain a motion
17 to approve Project 13-025, University of
18 Chicago Medical Center to add 38 beds to the
19 existing med/surg bed complement.

20 May I have a motion?

21 MEMBER GREIMAN: Motion.

22 MR. ROATE: Motion made by Justice
23 Greiman and seconded by Mr. Penn.

24 Mr. Bradley.

1 MEMBER BRADLEY: Yes.

2 MR. ROATE: Dr. Burden.

3 MEMBER BURDEN: Yes.

4 Even though I've been inundated with
5 conversation re the bypass situation, I
6 personally always wondered how -- it had 57
7 emergency room stations, why there was a
8 bypass problem going on at all with all that
9 emergency.

10 I'm going to vote yes for having beds.
11 Yes.

12 MR. ROATE: Senator Demuzio.

13 MEMBER DEMUZIO: Yes.

14 MR. ROATE: Justice Greiman.

15 MEMBER GREIMAN: Yes.

16 MR. ROATE: Ms. Olson.

17 CHAIRPERSON OLSON: Yes.

18 MR. ROATE: Mr. Penn.

19 MEMBER PENN: Yes.

20 MR. ROATE: Mr. Sewell.

21 MEMBER SEWELL: Yes.

22 MR. ROATE: Seven votes in the
23 affirmative.

24 CHAIRPERSON OLSON: The motion

13-045 - DAVITA TRC CHILDREN'S DIALYSIS

226

1 passes.

2 Last but not least for tonight, 13-045,
3 DaVita TRC Children's Dialysis, Chicago.

4 If the applicants could come to the
5 table, please.

6 Mr. Constantino, the State Agency
7 Report, please?

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

10 The applicants are proposing to
11 discontinue an existing six-station ESRD
12 facility in Chicago and reestablish an
13 eight-station replacement facility in the same
14 city.

15 The approximate cost of the project is
16 \$2.4 million. There was no opposition. No
17 public hearing was requested. This
18 application was read in an expedited review;
19 but according to the applicant, there were
20 deteriorating conditions at the existing
21 location.

22 We double-checked on that. IDPH did
23 look at that and agreed with that assessment.

24 MEMBER PENN: Mike, can you say

1 that last one again?

2 MR. CONSTANTINO: This application
3 was expedited because according to the
4 applicant, there were deteriorating conditions
5 at the existing location. We contacted IDPH,
6 and they verified that.

7 MEMBER PENN: Thank you.

8 CHAIRPERSON OLSON: Would the
9 applicants at the table introduce themselves
10 and be sworn in or vice versa?

11 MS. DAVIS: Penny Davis, Division
12 Vice President for DaVita. That's Penny,
13 P-e-n-n-y, Davis, D-a-v-i-s.

14 MR. SHEETS: Chuck Sheets. I'm an
15 attorney with Polsinelli representing the
16 applicant.

17 MS. COOPER: Anne Cooper, attorney
18 for DaVita. Polsinelli is spelled
19 P-o-l-s-i-n-e-l-l-i.

20 (The witnesses were thereupon
21 duly sworn.)

22 CHAIRPERSON OLSON: Comments from
23 the panel?

24 MS. DAVIS: Thank you. Good

13-045 - DAVITA TRC CHILDREN'S DIALYSIS

228

1 afternoon. My name is Penny Davis, the
2 Division Vice President for DaVita Health Care
3 Partners here in Chicago.

4 I'd like to thank the Board and
5 especially thank Board Staff for expediting
6 consideration of this project.

7 I'll keep my presentation very brief,
8 but this is a very different dialysis project
9 than you have heard from us in the past.

10 Since 1997, DaVita acquired Children
11 Memorial's dialysis program for their
12 children. We have been their partner ever
13 since. About ten years ago we located to a
14 building at 2611 North Halsted.

15 Over the last couple of years, we've
16 been getting more and more water damage in the
17 building basically from the street repairs and
18 the alleys are always full of water. This
19 last year with the heavy rains, we had
20 substantial damage down into the basement.

21 Our experts tell us that the building is
22 wet, and we all know that that can cause
23 problems for the children. Based on the fact
24 that these kids are immunocompromised and most

1 of them will go to transplant at some point,
2 we want to make sure we get them in a safe
3 place.

4 Our plan would be to relocate those
5 children to our Loop facility for a period of
6 time until a new facility can be constructed.

7 The problem is that we couldn't keep
8 them there long-term because as a designated
9 children's provider, we believe that the
10 pediatric population is very different from
11 the adult population and should not be mixed.

12 When you walk into the facility and you
13 see the little kids running around, you would
14 understand the very big difference with them
15 being with an adult population that is
16 oftentimes disabled as well.

17 When Children's Memorial moved last year
18 and became Ann & Robert Lurie Children's
19 Hospital, it moved them about a mile and a
20 half farther away from our current facility.

21 Our staff at the children's facility go
22 back and forth to the hospital because they
23 also provide the acute dialysis treatment to
24 the babies at the hospital and the kids at the

1 hospital. Then they come back to the Chronic
2 Unit.

3 So our goal is to move this to a closer
4 location, somewhere that is right near the
5 expressway as opposed to where it is up on
6 Halsted Street. It currently is 20 to 25
7 minutes to get from the Kennedy Expressway to
8 the current location.

9 I know that from a utilization
10 standpoint, we look like we're only running
11 about 50 percent. We run a schedule based on
12 the kids' needs; and so what we try to do is
13 just run a first and second shift. Many of
14 these kids go to school as well.

15 That's our reasoning for wanting to add
16 two stations so that we can also be able to
17 have more kids on an early morning shift prior
18 to school.

19 The existing facility also has no
20 parking, and so patients have dropped off on
21 Halsted Street, which can be, as anyone knows
22 the City, a very busy thoroughfare. The new
23 facility would have dedicated parking and a
24 drop-off zone for the kids.

1 While this project received some
2 negative findings, the findings don't take
3 into account that this facility is solely
4 dedicated to pediatric patients.

5 Although the University of Chicago and
6 the University of Illinois treat pediatric
7 patients, they only provide acute or
8 hospital-based services. They do not provide
9 chronic services.

10 One other facility in the area does
11 treat children, and that's FMC West Side, but
12 that's being done in an adult ESRD facility.
13 We believe, again, the children deserve to be
14 in a special place.

15 The size of the facility, what we are
16 doing is we're also going to be providing
17 peritoneal dialysis at the facility like we
18 currently do. Many children utilize
19 peritoneal dialysis until they have to go on
20 chronic hemodialysis, and it's our preferred
21 method.

22 In terms of transplants, in working with
23 the University of Chicago -- or Children's
24 Memorial, we have found that about 30 percent

13-045 - DAVITA TRC CHILDREN'S DIALYSIS

232

1 of the kids transplant. They don't transplant
2 as babies, though. They can't transplant
3 generally until they're about three. So many
4 babies need to be on dialysis for eight to
5 ten, twelve months until they can be
6 transplanted.

7 Again, we use specialized nurses. Only
8 pediatric dialysis-trained nurses take care of
9 these kids. We don't go back and forth
10 between adults and children. It's an all RN
11 staff so that the kids get a true nursing
12 assessment each time they are dialyzed.

13 We have children coming to this
14 facility, I will tell you, from up to 40
15 minutes away three times a week for four hours
16 at a time because this is a dedicated
17 pediatric facility associated with Children's
18 Memorial -- Lurie Children's.

19 So thank you. I'm ready to answer any
20 questions, and I'm sorry if I talked too long.

21 CHAIRPERSON OLSON: You didn't talk
22 too long.

23 Questions from the Board?

24 Dr. Burden?

13-045 - DAVITA TRC CHILDREN'S DIALYSIS

233

1 MEMBER BURDEN: Well, obviously,
2 you may or may not know from 1966 through 1997
3 I was full-time at Children's.

4 During the period of that time I was
5 there in pediatric nephrology, and we began
6 the transplant program, which I can tell you
7 is almost ancient history because things have
8 changed so drastically. I have no comment. I
9 just wanted to tell you my history.

10 You can't impress me more with the need
11 for what you're here today for. I would
12 explain to those on the Board who don't
13 understand that kids are different. They are
14 not neurotic. They take surgery well. They
15 need to have a facility closer to where the
16 mother house is. That's for sure.

17 But the question I raise is Kingsbury is
18 still West Loop, a very congested area.

19 Is that close enough to really
20 provide -- we've already discussed the
21 university's need for a renal dialysis unit at
22 Northwestern, which has created some
23 controversy.

24 But your location of distance, that to

1 me is still not like it was from Fullerton
2 Avenue. Well, I see you guys are two blocks
3 north of Fullerton. It was in the hospital
4 when I was there. That's how things have
5 changed, but now you're talking about West
6 Loop.

7 Does that satisfy the people involved in
8 making decisions now?

9 MS. DAVIS: Yes. We're actually
10 about a mile and a half closer than we
11 currently are.

12 Our nurses have already made the
13 decision they're just going to cab back and
14 forth because it's cheaper than parking at
15 Northwestern or Children's Memorial.

16 We think because of -- I mean, in the
17 old days, as you might recall, we used to --
18 from our current location to Children's
19 Memorial, we could literally wheel dialysis
20 machines down the street from the hospital to
21 the clinic.

22 Those days of trying to find space in
23 the Streeterville area where Children's
24 Memorial and Northwestern currently are, I've

13-045 - DAVITA TRC CHILDREN'S DIALYSIS

235

1 been looking for space there for almost two
2 years now.

3 Because of the situation with the water
4 in the building, it became far more urgent;
5 and the Kingsbury location, that was a
6 straight shot, and it's a quick five-minute
7 cab ride.

8 MEMBER BRADLEY: It's not actually
9 the West Loop at all. It's River North.

10 MEMBER BURDEN: Well, you're a long
11 way. You can talk about geography all day,
12 but it's a long way.

13 It seems to me for my purposes, if I
14 were still having a say -- and I'm not -- I'd
15 like it a lot closer than I think it is.
16 You're talking about very ill, especially
17 neonatal children. That's a tough job.

18 At any rate, I just wanted to emphasize
19 that I think it's absolutely appropriate to be
20 a lot closer to the institution, 100 percent.

21 CHAIRPERSON OLSON: Mr. Penn?

22 MEMBER PENN: The building that
23 you're moving out of, do you own that
24 building?

13-045 - DAVITA TRC CHILDREN'S DIALYSIS

236

1 MS. DAVIS: No, we do not. We
2 lease it, and our lease is up next year.

3 CHAIRPERSON OLSON: Would you give
4 me the stat just one more time?

5 There's one other pediatric dialysis
6 unit, which is where?

7 MS. DAVIS: There is a dedicated
8 pediatric dialysis unit at Rush, and that
9 facility is not part of a children's hospital
10 because they don't have a children's hospital.

11 Then at the University of Illinois and
12 University of Chicago, they both provide acute
13 dialysis services. So it's only when the
14 child is in the hospital. They don't have a
15 chronic unit.

16 CHAIRPERSON OLSON: And the other
17 units would mix the pediatrics in with the
18 adult?

19 MS. DAVIS: Right.

20 MEMBER BURDEN: Doesn't Lutheran
21 General have pediatric nurses?

22 MS. DAVIS: No, not on an
23 outpatient basis, and that's an hour and a
24 half away.

13-045 - DAVITA TRC CHILDREN'S DIALYSIS

237

1 They have a Children's Hospital. In
2 fact, we do the dialysis for -- DaVita Health
3 Care Partners -- so it's the same nurses -- do
4 the dialysis for both Lutheran General's acute
5 kids and Christ Hope Children's Hospital's
6 acute kids.

7 CHAIRPERSON OLSON: Other questions
8 or comments?

9 I'd like to entertain a motion to
10 approve Project 13-045, DaVita TRC Children's
11 Dialysis for discontinuation of a six-station
12 ESRD facility and establishment of an
13 eight-station replacement facility.

14 May I have a motion?

15 MEMBER PENN: So move.

16 MEMBER GREIMAN: Second.

17 MR. ROATE: Motion made by Mr. Penn
18 and seconded by Justice Greiman.

19 CHAIRPERSON OLSON: Roll call.
20 Please?

21 MR. ROATE: Mr. Bradley.

22 MEMBER BRADLEY: Yes.

23 MR. ROATE: Dr. Burden.

24 MEMBER BURDEN: Yes.

13-045 - DAVITA TRC CHILDREN'S DIALYSIS

238

1 MR. ROATE: Senator Demuzio.

2 MEMBER DEMUZIO: Yes.

3 MR. ROATE: Justice Greiman.

4 MEMBER GREIMAN: Yes.

5 MR. ROATE: Ms. Olson.

6 CHAIRPERSON OLSON: Yes.

7 I want to explain my yes vote for the
8 record. It's based on the fact that this is
9 strictly a pediatric unit; and despite the
10 fact that there are units in the area not at
11 full utilization, they are nonpediatric units.
12 So I'm voting yes.

13 MR. ROATE: Mr. Penn.

14 MEMBER PENN: Yes.

15 MR. ROATE: Mr. Sewell.

16 MEMBER SEWELL: Yes.

17 MR. ROATE: Seven votes in the
18 affirmative.

19 CHAIRPERSON OLSON: Motion passes.

20 MS. DAVIS: Thank you so much.

21 CHAIRPERSON OLSON: Congratulations.

22 MR. SHEETS: Thank you.

23 CHAIRPERSON OLSON: That brings us
24 to the end of our business for today. We are

REPORT OF PROCEEDINGS - 8-13-2013

241

1

2