JUNE 28 TRANSCRIPTS
MERCY CRYSTAL LAKE
#10-089

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

OPEN SESSION

JUNE 28, 2011

DAY 1

STATE OF ILLINOIS

HEALTH FACILITIES AND SERVICES REVIEW BOARD

525 West Jefferson Street, 2nd Floor

Springfield, Illinois 62761

217-782-3516

OPEN SESSION

DAY 1

The regular session of the meeting of the State of Illinois Health Facilities and Services Review Board was held on June 28, 2011, at Holiday Inn Joliet Conference Center, 411 South Larkin, Joliet, Illinois.

PRESENT:

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

ALSO PRESENT:

Courtney Avery - Administrator
Cathy Clarke - Assistant
Frank Urso - Legal Counsel
Juan Morado
Michael Constantino - IDPH Staff
George Roate - IDPH Staff
Bill Dart - IDPH Staff
David Carvalho - Deputy Director, IDPH
Michael C. Jones - IDFS
Mike Pelletier - IDHS

Reported by:
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MR. CARVALHO: Everyone is operating from it, and you will hear -- if past is any prediction, you will hear people argue either side of this, depending on how it affects their application, and we wanted to give you an objective statement of what's wrong about the inventory and what's weak about it and acknowledge that.

CHAIRMAN GALASSIE: Thank you very much.

We are going to move forward now with Item I, No. 1, 10-089, Mercy Crystal Lake Hospital. We have approximately how many public comments?

MS. AVERY: Fourteen.

CHAIRMAN GALASSIE: We have fourteen people who have asked to speak. Again, if you could please try and keep your comments focused into a couple of minutes, we would greatly appreciate that. When you do come up -- and we'll keep you introduced a couple ahead -- if you'll introduce yourselves and be sworn in, and following that, we will have the applicant here.

If Board members can, we would prefer to hold questions for the applicants rather than those individuals representing the public.

That having been said, if you're a member of the public and you're coming up to speak for your two minutes and you desire to speak if you're for or against,

you have every right to do so, nor do you have to do that. If you would prefer to advise us of your stand, feel free to do so.

We're going to try to cue up. We'll read three or four names at a time so we can cue up to move things along.

(Ms. Avery identifies individuals by name.)

MR. URSO: If everybody can, please sign the yellow pad that's by the microphone.

CHAIRMAN GALASSIE: Good morning.

MR. COLBY: Good morning. I'm Dan Colby.

MR. KURTZ: I'm David Kurtz.

MS. BORTNER: I'm Barb Bortner.

MR. COLBY: Good morning, Mr. Chairman and the Board. First of all, I'd like to thank you for the opportunity to speak this morning and, secondly, I'd like to mention that I did speak at the public hearing but on a different topic.

As far as myself, I've lived in Harvard, McHenry County, Illinois for the last 15 years. I serve on the Harvard and McHenry County Economic Development Commissions. During this time, I have had a close, personal view of McHenry County's significant growth in population, retail industry, and the need for healthcare

services. In 2003, the Mercy Health System answered direct patient needs of McHenry County when it purchased Harvard Hospital and invested over $20 million over the next several years to provide excellent healthcare services for the patients of northwest McHenry County. This area's healthcare needs are now well served.

The southeast area of McHenry County also needed a hospital. But today, eight years later, the population of southeast McHenry County is a staggering 160,000 people, and still there is no hospital. Centegra continues to ignore this area because that 160,000 people include the greatest concentration of Medicaid recipients in McHenry County, the greatest number of elderly in McHenry County, even more than Del Webb in Huntley -- and this is per the 2010 census -- the greatest minority population in McHenry County -- again, per the census -- the greatest number of patients needing public transportation to healthcare services in McHenry County -- and that's per Metra and Pace -- the greatest number of patients needing ambulance transport to emergency services -- and that's per the Crystal Lake Fire and Rescue Chief.

Today Mercy wants to invest $200 million to serve the still needy community. On the other hand,

Centegra has chosen to ignore this need for the last eight years and instead wants to bypass this critical area to follow the growth and new money of Huntley. Of Huntley's 26,000 people, over 10,000 are comfortably retired individuals in new condos, who do not have healthcare access problems. Centegra had eight years of opportunity to serve the greatest need in McHenry County --

CHAIRMAN GALASSIE: Stay on course.

MR. COLBY: I'm sorry.

I just wanted to urge the Board to approve what is needed now, and what is needed now is the Crystal Lake Hospital, where the population is and where we don't have to worry about population growth and what the need might be in the next three to five to eight years.

Thank you.

MR. KURTZ: Good morning. I would like to thank the members of the Health Facilities Planning and Services Review Board for the opportunity to address the critical issues of timing and cost for this very important project.

CHAIRMAN GALASSIE: And your name, sir?

MR. KURTZ: David Kurtz.

CHAIRMAN GALASSIE: Thank you.

Our country has been slow to recover from the

deepest recession that any of us have seen in our lifetime. As a result, the construction industry has experienced intense pressure to hold down building costs in order to generate a sustainable level of business through these trying economic times. Subsequently, with new construction pricing currently at bargain basement levels, now is the time when any project would benefit fiscally from a bid perspective within the current economic environment.

Mercy is uniquely positioned to start this project within the current calendar year. This will not only maximize the purchasing power of each and every capital dollar spent, but provide a much-needed boost to the local construction industry as well. With a projected total project cost of $200 million, the 128-bed Mercy Health System proposal is already 33 (inaudible) Centegra project of $233 million. Common sense would seem to dictate that as the economy improves and back-up building projects are brought forward for implementation, construction costs will follow demand, and rise accordingly.

The Centegra project is not anticipated to begin earlier than the end of 2014. Following historical trends, we can expect prices to increase significantly over that period of time. The current gap of 33 million between

the two projects could widen dramatically as the inflation pressure associated with this delay becomes a factor with the Centegra project. The higher project costs associated with the existing Centegra proposal, coupled with the inflation area spiral brought on by the delay, will translate directly to higher healthcare costs for McHenry County. In turn, this added burden will have influence on the ability of McHenry County residents to access appropriate healthcare services.

It is readily apparent that Mercy Health System's proposal is the right project at the right place at the right time. Thank you for your consideration.

CHAIRMAN GALASSIE: Thank you.

(Ms. Avery identifies individuals by name.)

CHAIRMAN GALASSIE: Thank you.

MS. BORTNER: Thank you for the opportunity to address the Board today. My name is Barb Bortner, and I am Vice-President for Mercy Health System.

Mercy's mission is to provide exceptional healthcare services, resulting in healing in the broadest sense. "Healing in the broadest sense", for Mercy these five small words make all the difference. Imagine for a moment you live in a community like Harvard, Illinois, a community we are privileged to serve. In 1996, you may

have attended an open house at our newest hospital in Harvard and taken part in one of the free health screenings or wellness checks we offered to the Harvard residents. Today you might visit one of our 87 primary and specialty care physicians at our 17 Illinois clinics. If you need hospital care, Harvard Hospital, with more than $20 million in renovations and service expansions, is ready to care for you. You might marvel that this hospital was once on the verge of extinction. Not only did Mercy renovate the facility but also enhanced the services and technology offered to the residents of the Harvard community, and last year alone, we touched the lives of over 8,000 residents in the town of Harvard.

System wide, Mercy provides $38 million in uncompensated care and free services to our communities. In Illinois, we provide more charity care as a percent of revenue than any other health system in McHenry County. As part of the Mercy family of 17 clinics in Illinois communities, over 87 Illinois, employed physicians provide over 60 specialty services. These dedicated physicians participate in over 5,000 free screenings, health classes, physician presentations, and wellness talks each year. We also enjoy working side-by-side with many community organizations by sponsoring and participating in hundreds

of events, walks and fairs each year.

We don't measure our ability to serve by the wealth of a community or its residents. Mercy is committed to doing whatever it takes to keep McHenry County, every part of McHenry County, healthy and strong.

Thank you for your consideration.

CHAIRMAN GALASSIE: Thank you, Barb.

If you folks can please be sworn in, and then as you individually speak, you can introduce yourselves.

(Oath given)

MS. LAMBERT: Good morning. I'm Karen Lambert, President of Advocate Good Shepherd Hospital, and I want to thank you for giving me the opportunity to speak today. We have a number of speakers who are coming to share their concerns about this project, but many are in the room because of their concern for the impact on these hospitals, and I would ask that they stand today just to be acknowledged.

(Pause)

MS. LAMBERT: I'm here today because this hospital will have a significant negative impact on many of the area hospitals and is truly inconsistent with our collective responsibilities to be stewards of the healthcare resources. One of the primary purposes of the

Planning Act is to prevent unnecessary duplication of services, and I believe this project does that. Existing hospitals need sufficient volume to cover their overhead. Within any given area, there are only so many babies to deliver or so many surgical procedures to perform. A new hospital will not create new demand. Without sufficient patients, hospitals can't continue to reinvest in the future or take care of patients who don't have the ability to pay.

If I can explain a little bit more, there's a few key items. We need better care, not more care. We're concerned with our safety net services. As a faith-based, not-for-profit, mission-oriented organization, Advocate Healthcare provides more indigent healthcare than any other provider in the state of Illinois. The impact of this hospital seriously impacts the ability for area hospitals to provide safety net services.

In a few minutes, you're going to hear from my colleague, Michelle Gaskill, who is going to explain how the resources at Good Shepherd are vital to carrying on our mission at Advocate and serving some of the under served areas. We believe there is no need under the review rules, and we're grateful that the State Agency Report has confirmed that this project is an unnecessary duplication

of services.

And then lastly, we don't believe there's a practical need. There's no patient who is going untreated because an area hospital is full. Every resident has a hospital within 30 minutes, and 90 percent of the residents have a hospital within 15 minutes. We believe this project will negatively impact area hospitals, and it is not responsible use to healthcare resources, so we urge the Board to deny this project.

Thank you.

CHAIRMAN GALASSIE: Thank you.

MR. FLOYD: Good morning. My name is Rick Floyd. I'm the President and CEO of Sherman Health, which is based in Elgin, Illinois. Sherman has been serving the Northern Fox Valley service area for 23 years. I am here today to oppose this application, because there is no need for additional beds in our service area. All of the adjacent hospitals have unused capacity. The State Report identified utilization rates for medical/surgical beds of 74.5 percent for the five surrounding hospitals and 45.5 percent in OB for those same hospitals.

Also, you are aware that the impact of healthcare reform upon all hospitals will be to reduce hospital utilization rates as we strive to prevent

unnecessary readmissions and to find more cost-effective ways to treat patients in the outpatient arena. Therefore, if you build a new hospital, it hurts all the existing hospitals. In the case of my hospital, we estimate that this application, this new hospital, would take about 2,000 admissions away from us. That's about 15 percent of our volume, and that would put a big dent in anyone's revenue, and this happens at a time, also as a result of healthcare reform, when reimbursement rates, when payment rates to hospitals and doctors are expected to decline significantly.

So, why does this matter to the Planning Board? It matters, as Ms. Lambert pointed out, because it calls into question the strength of our safety net. All of us provide services to those who cannot pay, to those who are part of Public Aid, and this is going to place additional strain for all of the existing hospitals. Also, as Mr. Carvalho pointed out in his very clear and helpful explanation, the population projections that serve as the basis for these applications and also for the bed-need estimates were based on over estimates, significant over estimates of population. Therefore, there is no existing bed need, and there will be no need for quite a while.

So, I urge the Board to reject this

application. It's a waste of public resources at a time when state and federal budgets are experiencing historic Imbalances.

Thank you.

CHAIRMAN GALASSIE: Thank you.

MR. NEMETH: Hello, my name is Joe Nemeth, and I am the Chief Operating Officer of Mercy Care Insurance Company. I'm here today to speak to you about why I believe you should approve the CON for Mercy Health System to build the Mercy Crystal Lake Hospital.

Mercy Care Health Plans has been a licensed Illinois insurer for the past 10 years, and I can tell you firsthand that without significant new competition to the Centegra Health System, there is little belief, little reason to believe that there will ever be multiple insurers serving the McHenry County market. With inpatient and outpatient costs accounting for about 50 percent of the total health insurance bill, Centegra Health System by its monopoly in that area dictates what insurance companies operate in McHenry County. Because Mercy Care is a wholly-owned subsidiary of the Mercy Health System, Centegra has basically been -- we've been unable to compete, because Mercy Health System operates a competitive provider network to Centegra. So, basically the Mercy Care

Insurance Company has not been able to get contracts with Centegra that would be equivalent to what they give to Blue Cross/Blue Shield of Illinois, for example. There is no requirement by any health provider in this area to contract with any insurer under any rates. So, even though the health CON process attempts to control costs by avoiding duplication of services, because of the lack of competition in this marketplace, I believe it is actually increasing costs. This finding is consistent with the 2007 U.S. Department of Justice and the U.S. Federal Trade Commission's study that talked about CON and it's impact on competition and on cost.

Also, Mercy is a vertically-integrated delivery system which coordinates care from a physician office through the hospital services, and this model has shown to be a cost-effective model. For these reasons I encourage you to approve the Mercy Health System CON.

Thank you.

CHAIRMAN GALASSIE: Thank you.

(Ms. Avery identifies individuals by name.)

(Oath given)

MS. RIPSCH: Hello. My name is Sue Ripsch, and I'm Vice-President of Mercy Health System. Thank you for this time to share my thoughts about the Mercy Health

System commitment to the residents of McHenry County.

In 2003, Mercy Health Systems assumed the operations and financial responsibility for Harvard Memorial Hospital in Harvard, Illinois. At that time, Harvard Memorial Hospital had reached financial insolvency. They sought out two area providers, Mercy Health System and Centegra Health System, looking to find a partner. When meeting with Centegra, Harvard Hospital was told that they could join but that Centegra planned on essentially shutting them down and moving their services out of town. Please be aware that Harvard has a lower social economic level than many other areas in McHenry County and that healthcare is sorely needed by this community.

When meeting with Mercy, Mercy made the commitment to not only keep the facility open but to improve the physical plant and expand services to the residents of Harvard and the surrounding area. In honoring that commitment to the Harvard area residents, Mercy has injected $20 million into the facility with improvements in the operating rooms, the emergency department, lab, radiology, long-term care, and respiratory services. We have computerized the inpatient medical records with an electronic medical record system. This has been at a cost but has greatly benefited the community.

Incidentally, none of these projects met the capital project threshold. We have added many physicians and physician services to the hospital. We would do the same at the Crystal Lake Hospital, if approved. In addition, Mercy's policy is to give healthcare to those patients Mercy serves, including the proposed hospital at Crystal Lake, regardless of their ability to pay. Again, no other healthcare provider in the county was willing to step up and invest in the healthcare services for a very needy area of McHenry County as we have done in Harvard.

Mercy Health System is committed to all residents of McHenry County. We do not pick and choose who we care for. Mercy has the financial means and the commitment to meet the needs of the residents of this area. I recommend that you approve the Mercy CON request for a needed hospital in Crystal Lake.

Thank you.

CHAIRMAN GALASSIE: Thank you.

MS. GASKILL: Good morning. My name is Michelle Gaskill. I'm the Vice-President of Nursing and Clinical Operations at Advocate Trinity Hospital, and I'd like to start out by thanking you for giving me the opportunity to speak to you today. You may be wondering why I'm speaking from a hospital's standpoint that is

actually 60 miles away from the healthcare landscape that we're talking about. But the answer to that is Advocate loses millions of dollars every year serving Chicago's south side. When the financial strings of Advocate Good Shepherd are threatened, our inner city mission is to serve those in need. I'm very proud to say that Trinity right now ranks nationally in the top 10 percent of hospitals as it relates to heart attacks, to stroke, pneumonia, and also surgical care. We just got designated as a Stroke Center of Excellence, which was critical to our community, because our zip code where the hospital resides is actually the highest incident of stroke in all of Illinois. This over the years has only been possible because of investments that Advocate has made in Trinity, despite the fact that reimbursement tends to be low and charity care is high.

From 2006 to 2010, Advocate lost $31 million in the Trinity service area and provided $47 million in charity care, despite those losses, and spent $5 million to build services, such as a wound care center, that will meet the needs of our population. Trinity can only continue to thrive and build these services for our community because of the income from operations and communities like Barrington. A recent study estimated that if the Crystal Lake hospital is built, hospitals in the immediate area

would lose $144 million in revenue and $51 million in contribution margin. These losses will undoubtedly adversely impact the communities those hospitals serve.

Yet that's only half the picture. A new hospital in McHenry County will have adverse consequences for families on Chicago's south side for all of the reasons that I mentioned. So, I'd like to ask this Board to vote no on this proposal.

Thank you very much for your time and attention.

CHAIRMAN GALASSIE: Thank you, Michelle.

MR. STILSON: Thank you for allowing me to have the opportunity to speak today. My name is Dr. Matthew Stilson. I'm the Medical Director for the Emergency Department and the Urgent Care Center at Sherman Hospital. I'd like to address the issue of providing state-of-the-art emergency department services in our area.

On the surface, it may appear that building emergency rooms, building more emergency rooms in more locations, would improve emergency care. But actually the most important element in a true emergency is how long it takes the paramedics or the EMT's to reach and stabilize that patient. The time it takes the ambulance to drive the patient to the hospital is less crucial. It's also

important to put trauma care in perspective. Approximately 1 in 100 patients seen in the emergency room represents a true trauma case. The vast majority of cases are far less urgent.

Once a patient with a life-threatening condition arrives at a hospital, it's important that that facility have the right team ready to treat the patient and do surgery immediately, if necessary. Sherman's state-of-the-art emergency department is already providing that type of quality care very efficiently for patients in southern McHenry County. We're also well prepared for all those patients when they arrive at the emergency department, because we've been in close communication with paramedics who are treating the patient. Often our treatment begins before a patient even arrives at our door.

Sherman is meeting the emergency room needs of the area right now and is committed to continuing in that role. I urge the Board to reject the new hospital construction in our area. I believe it would be a costly duplication of services.

Thank you.

CHAIRMAN GALASSIE: Thank you.

MR. GORDON: Good morning. My name is Trent Gordon, and I'm the Director of Business Development and

Strategic Planning at Advocate Good Shepherd Hospital. I'm opposing the proposed Mercy Hospital. Approving the Mercy Hospital would cause an unnecessary duplication of services in the area.

So, you may wonder if there are so many hospital choices, why then is there a calculated need for 83 more medical/surgical beds? The bed need is primarily based on recapturing the patients leaving the county for care. The calculation of the 83 med/surg beds is based on patient utilization off of a base year of 2005, multiplied by a factor to account for the forecast growth and the aging of the population through 2015. As Mr. Carvalho pointed out, the population projections for this particular planning area were 9 percent higher than what the actual census showed. However, the forecast utilization for 2015, based on the over-stated population and aging, shows the bed need for only some of the 83 beds.

So you're probably wondering why then is the application citing the bed need for 83? The reason is that some of the 83 bed need is based on recapturing a lot of the patients who are currently leaving the county to go to hospitals located outside of the county. I think that "recapturing" is an interesting word here. Patients are going to other hospitals out of choice, because as you have

heard, there are empty beds in McHenry County. I should mention that many of those beds included in the calculated 83 would, according to the formula, be recapturing patients traveling less than one mile beyond the county border to Good Shepherd. A lot of these patients are also going to academic medical centers downtown and specialty hospitals, such as the University of Illinois Medical Center and Children's Memorial, to receive care not currently offered or planned to be offered by the applicant. In fact, if Good Shepherd were located one mile west of its current location and was in McHenry County, then at least 20 fewer med/surg beds would be needed in McHenry County, or only 63 beds and, in fact, if you recalculated the population, basing it on a 9 percent lower base, which is what the census demonstrated, off of 300 bed need, there would be 29 fewer bed than that, meaning that there would be a calculated need of only 34 med/surg beds, which is far less than the 100 med/surg beds needed for a new hospital.

I urge the Board to take this into account as you make a decision. Thank you.

CHAIRMAN GALASSIE: Thank you, Trent.

(Ms. Avery identifies individuals by name.)

(Pause)

CHAIRMAN GALASSIE: Good morning, and if you

folks can all be sworn in together and sign in on that sheet as well, and then introduce yourselves individually as you speak to the Board, please.

(Oath given)

MS. DEERING: Good morning. I'm Linda Deering, Executive Vice-President and Chief Operating Officer for Sherman Health, and thank you for letting me verbalize my opinion about opposition for this hospital, and it's based on the Comprehensive Health Planning issue. Let me explain.

Sherman Health believes that until the State establishes a Center for Comprehensive Health Planning, the Illinois Health Facilities and Services Review Board should not consider applications for a new hospital at this time. As you know, the Center for Health Planning was a crucial part of the Illinois General Assembly's 2009 rewrite of the Illinois Health Facilities Planning Act. It makes sense then to honor the Legislation's direction by deferring any new hospital applications until that center is established. The Center for Health Planning will provide very important planning assistance to the Board. The Center will analyze CON applications, review reports and statistics related to those applications for new hospitals. Ultimately this and in-depth planning will help the Board make decisions that

ensure access to healthcare for under served populations and promote efficiency. This will also ensure that existing hospitals remain in strong financial health so that they can continue to serve the patients who are most in need.

Healthcare efficiency is critically important for the fiscal well-being of our state and our nation. Taxpayers pay for more than half of the healthcare costs in this country through Medicare and Medicaid. The Centegra and Mercy hospital proposals would create a duplicative, inefficient healthcare environment, and everyone will pay for it as insurance costs rise to pay for more buildings that are staffed 24/7, even if they're under utilized. The plans from Centegra and Mercy go to the core of what the Comprehensive Planning function is intended to address, whether population growth has truly occurred, utilization rates of existing healthcare providers, the regional implications of pending projects.

We hope that Mercy and Centegra projects and all other new hospital applications will receive the kind of analysis they need before the Board makes any decisions of this magnitude. In closing, we encourage the Board members to take advantage of this opportunity provided by the State law. The Center for Comprehensive Health

Planning will give Board members the kind of in-depth analysis they need before voting on these proposals. When this much is at stake for our most vulnerable residents and all taxpayers, it's clear that this center is needed now more than ever.

Thank you for letting me be heard.

CHAIRMAN GALASSIE: Thank you.

MR. RYDER: Good morning. My name is Doug Ryder I'm the Vice-President of Operations and Service Lines for Advocate Good Shepherd Hospital. I'm here to voice my opposition. I'm asking the Board basically to do what's practical. Denying these applications today won't negatively impact the health of McHenry County residents. If you vote no, there won't be a resident who needs surgery that doesn't get surgery. There won't be a woman who doesn't deliver at a nearby hospital. All of the residents of the proposed hospital reside within a 30-minute drive of a quality hospital and approximately 90 percent within 15 minutes. There is not a practical need for another hospital.

I can assure you that adding another hospital in McHenry County will adversely affect existing area hospitals and the patients and communities they serve. Indeed, Centegra has pointed out that the addition of the

Mercy Hospital in Crystal Lake would have a deleterious impact on patient volumes at these hospitals and would result in severe financial distress. The same can be said of Centegra's proposed hospital, as it would, no doubt, harm existing hospitals.

Centegra was right. A new hospital in the near proximity to hospitals not fully utilized causes considerable harm. Let me give you a historical perspective. In the last 30 years, this Board has approved only one hospital, one new hospital. That hospital was Adventist Bolingbrook Hospital. Three years after opening, that hospital is only operating at 40 percent occupancy, well below State standards. It's a hospital with lots of empty beds. At the time of the application, Bolingbrook's population was forecasted to grow even faster than McHenry County's projected growth, and there were fewer nearby hospitals.

Approving new facilities is one of the biggest decisions tasked to this Board. Many complex concerns have been raised, including adverse impact on quality, safety net care for the vulnerable, unnecessary duplication of resources and costs.

If there is any doubt in your mind, then you shouldn't move forward. Rather, wait until the

State-mandated comprehensive plan or function is in place and an independent impact study has been conducted. That planning function was passed into law for just such a case as you are voting on today.

Let me close where I started. Nothing adverse will result from denying these projects today.

CHAIRMAN GALASSIE: Thank you very much.

MR. OURTH: Good morning. I'm Joe Ourth, and as Legal Counsel for Sherman Hospital, Advocate Good Shepherd Hospital, and St. Alexian Medical Center, I submitted a letter, requesting that the Board defer action on new hospital projects until the Comprehensive Planner Rule has been fulfilled. Before you on the record is literally thousands of pages of public record. You've heard, you've seen many witnesses come before you, some for, some against the project. For you as Board members, you're accustomed to making difficult decisions, both as a Board member and in your non-CON lives. Reasonable decision makers want to know what's the context in which you make those decisions? What's the policy context? What's the goal that we're trying to achieve.

Two years ago when the Illinois General Assembly rewrote the Illinois Planning Act, they did so with two purposes in mind: One, to establish reforms and

to reconstitute the Board to address some of the corruption issues that had plagued past boards; and, two, and equally important, they established a role of a comprehensive health planning function. Essentially, what the Legislature thought was you create a comprehensive planning function which sets policy for the state, and you then have a review board that decides individual, specific projects and whether that project is consistent with the overall plan. As you know, the Center for Comprehensive Planning still awaits implementation.

The decision on approving the establishment of hospitals is one of the biggest decisions that this Board makes. The Board's voluntary deferral of a hospital approval would be prudent and, despite the applicant's desire for an immediate decision, would be well within the Board's powers. As Doug explained there is no urgency for a decision. New hospitals are long-term decisions. McHenry County residents are not deprived hospital care because they can't get a bed at the present time, and if the applicants truly believe that there was a great need in McHenry County, they should not be afraid to wait for a comprehensive plan to see that that validates that. Or perhaps they anticipate that a new hospital in suburban McHenry County may not be foremost in the State's health

plan.

The Planning Act here clearly contemplates a comprehensive planning function to work with the Review Board. That action would not only be consistent with the legislative intent but a prudent planning process and clearly within the Board's power.

CHAIRMAN GALASSIE: Thank you.

MS. CUTLER: Members of the Board, my name is Elyse Cutler, and I'm the Vice-President for Strategic Planning for the Advocate Healthcare System. In that capacity, I oversee our CON work system-wide.

I appreciate the challenge you have before you today, particularly in light of the lengthy record that has been established for this project. With that challenge in mind, let me reiterate and summarize the key points of the opponents to this project. One, the Mercy project is duplicative. Two, the Mercy project will damage other hospitals' financial stability, including Good Shepherd, whose financial strength allows Advocate to serve the inner city. Three, the methodology used by the applicant to establish bed need is flawed and relies on population growth projections from before the housing market crisis. Four, the most recent new hospital to be built in Illinois is currently at just 40 percent capacity. Five, voting no

will have absolutely no negative impact on anyone's access to healthcare. Six, we believe that a comprehensive state health plan should be in place prior to making decisions about new hospitals.

Also, in closing, some of you would believe that today the choice is about Centegra versus Mercy. We respectfully disagree with that. We would say that the decision today is really about whether a new hospital is needed in McHenry County, and we ask that you reflect on this question, looking at the evidence and vote no.

Thank you.

CHAIRMAN GALASSIE: Thank you. Are there any other members who wanted to speak publicly on this item?

(Pause)

CHAIRMAN GALASSIE: Hearing none, thank you very much. We appreciate your input.

I would invite the applicants to the table, please, from Mercy Crystal Lake Hospital.

(Pause)

MR. CONSTANTINO: Mr. Chairman, we received a comment on the State Agency Report we'd like to distribute at this time.

CHAIRMAN GALASSIE: Okay. While you folks are coming up -- and we would like to ask you to sign on that

sheet -- we're going to ask for a Staff Agency Report.

MR. CONSTANTINO: Thank you, Mr. Chairman.

The applicants, Mercy Crystal Lake Hospital and Medical Center and Mercy Alliance, are proposing a 128-bed hospital, 100 med/surg beds, 20 OB beds, and 8 ICU beds in Crystal Lake, Illinois, in approximately 265,000 departmental gross square footage, at a cost of approximately $200 million. The applicants are before the State Board today because they propose the establishment of a healthcare facility as defined by the Act.

The public hearing was held on this project on March 18th, 2011. 52 individuals spoke in support and 68 individuals spoke in opposition. In addition, the State agency has received a number of support and opposition letters that are in your -- the packet of information that was sent to all of the Board members.

The State Agency would like to note the following: There's a calculated bed need in 2015 of 83 med/surg beds, 8 ICU beds and 27 OB beds. The number of medical/surgical beds requested by the applicant of 100 exceeded the calculated need. 6 hospitals within 30 minutes are not at target occupancy for the service provided by this project. Specifically, 4 of the 6 hospitals were not at target occupancy for med/surg

services, and no hospital within 30 minutes was at target occupancy for OB services. All 6 hospitals met the target occupancy for ICU services.

The applicants exceeded the State Board standard for OB rooms by 23 departmental gross square footage and exceed and the A & E fees proposed exceed the State Board standard by 1.52 percent or $1,024,287.

Thank you, Mr. Chairman.

CHAIRMAN GALASSIE: Thank you, Michael.

MR. URSO: Mike, you handed out the comments for this --

MR. CONSTANTINO: Yes. The letter asks the State Agency Staff to include comments provided by CEO's of facilities within 30 minutes, specifically Advocate Good Shepherd and Sherman Hospital, comments from a U of I study, and consideration that the State Board not act until such time as the Comprehensive Health Planning function was established as required by the Act. In addition, the letter asks that we include information regarding the safety net impact referenced in the letter in the SAR, which states that the proposed project would have a significant negative impact on other area hospitals, including the loss of approximately 9,700 discharges, $144 million in lost revenue, and 51.5 in lost contribution

margin.

Thank you, Mr. Chairman.

CHAIRMAN GALASSIE: Thank you, sir.

(Oath given)

CHAIRMAN GALASSIE: Can I just ask who intends to speak to the subject.

MR. URSO: Now, we received comments during the SAR comment period in this particular application. Mike just alluded to those. What this Board has the discretion to do at this point in time is several things. Because we have received comments between this period of time, the Board can reject those comments as one of its options, they can accept those comments and proceed, consider and listen to this application, or they can refer the matter back to Board Staff because there is something in the comments that perhaps the Board thinks needs further clarification or confirmation. So, because, once again, we have received comments through the State Agency Report, the Board needs to determine, number one, accept those comments and then consider the project. Number two, reject those comments, or, number three, accept those comments but they need further analysis by the Staff. So that's a decision that the Board has to make at this point in time, that they have the discretion to make.

MR. EAKER: Mr. Chairman, I have a question. Before the applicant makes their presentation, I would like to hear more about this comprehensive plan. Is it something that's in the near future? How is that proposed, or is it?

CHAIRMAN GALASSIE: That's a very appropriate question. I'll take a stab at it and then maybe David can jump in.

The Legislature, in its infinite wisdom, proposed the development of the Center for Comprehensive Health Planning, which is the good news. The complication is it hasn't been funded. So, as of now, unless I'm going to hear something I wasn't aware of this morning, it does not exist. But certainly the plan and the intention is to move forward with the funding of this center. We would then be working with them. Though no obligatory responsibility to follow their recommendations, one would certainly expect that we would have a working relationship, we would want to see their recommendations.

MR. EAKER: As some have suggested that we should be defer until this plan is done, if we -- if we were to take that action, would that put pressure, so to speak, for that comprehensive plan to be developed, or would it be the same effect as deferring to an indefinite

time, delaying to an indefinite time the decision?

CHAIRMAN GALASSIE: I, frankly, don't know. Does someone else want to try that? David?

MR. CARVALHO: Dave Carvalho, IDPH. And thank you, Mr. Chairman. That's a very succinct summary of the situation.

The -- when the Bill was pending, we estimated that it would take, when it was up and running, somewhere between a million and a million and a half dollars to fully fund the Comprehensive Health Planning Center. The purpose of the Center includes what you do, but goes well beyond it. The purpose of the Center is to look at work force needs, is to look at types of facilities that you do not regulate. As you know, you have jurisdiction over only what you have jurisdiction over, and so the Comprehensive Planning Center was intended to be comprehensive.

Were we to receive funding, which we did not in the current budget, which is the budget that rules for the next year -- were we to receive funding next year, we estimated that it would be anywhere between six months and nine months to staff it up, and then it would certainly be a year before it would actually develop a comprehensive health plan throughout the state. So, it is not a realistic expectation for there to be a comprehensive

health plan from a Comprehensive Health Plan Center for several years.

MR. EAKER: Thank you.

CHAIRMAN GALASSIE: Thank you.

MS. AVERY: David, I'm sorry. I was discussing something with Frank, but did you give a time frame for when the Center would be up and running?

MR. CARVALHO: I gave a time for both the Center and the plan, because once the Center is up, it will take some time for it to develop a comprehensive, state-wide plan at the level of detail that you would need to deal with every planning area in the state.

Having said that, if I might, if you'd like me to -- the specific issue, the interplay between the Comprehensive Health Plan Center and what you do is probably something else you should be aware of and thinking about. The reason why the Legislature felt there was a need for a Comprehensive Health Plan Center was because, I think, in looking at the history of the Planning Board over the last twenty years, it saw that the Planning Board functioned to turn down things or approve them, but the Planning Board had no roll in affirmatively going out to solicit that things be done. So, for example, your inventory might indicate that a particular area had a

particular need, but then your tools were to sit back and wait for somebody to make an application to do that or not, and that was the end of things. And so one of the things that they wanted a Comprehensive Health Planning Center to do was to develop an affirmative strategy for securing unmet needs. They did not want to delegate to a planning -- an agency of State Government the tools to do it either. They viewed those as being prerogatives of the Legislature.

So, the idea was the Planning Center would develop a plan and then perhaps suggest to the Legislature that there is an area over here that has need for more surgical capacity, the marketplace doesn't seem to be leading to applications for that, perhaps because of the payor mix that area probably would produce, and so some sort of subsidy or State capital investment or other mechanism would be necessary, and then the Legislature could respond to that. So, even if the Planning Center were up and running, you would continue to serve the role of doing -- and this is a descriptive, not a pejorative, negative planning, saying yes or no to things that come up, But then the Planning Center would be looking to solicit things, and that's how the two would interplay.

CHAIRMAN GALASSIE: Thanks, David. Ready to

move forward?

MR. PENN: Mr. Chair?

CHAIRMAN GALASSIE: Yes.

MR. PENN: I'd like to make a motion that we do accept this letter from Arnstein & Lehr, and I would like the motion to include that we defer this application and send it back to our Staff for further analysis of this report of the University of Illinois College of Medicine.

CHAIRMAN GALASSIE: Strictly all in reference to this?

MR. PENN: Yes. I accept this report.

CHAIRMAN GALASSIE: So, we are accepting the report and referring it to Staff?

MR. PENN: And defer the application.

CHAIRMAN GALASSIE: The application being 10-089, Mercy?

MR. PENN: Mercy, yes.

CHAIRMAN GALASSIE: Can I just make a suggestion we make a motion on this item in and of itself, and if there is a separate motion to defer the agenda item --

MR. PENN: Yes. Do I have to restate the motion?

CHAIRMAN GALASSIE: You don't. The motion

will be to accept this document and refer it to Staff to review.

MR. HILGENBRINK: Second.

CHAIRMAN GALASSIE: Thank you. Can I get a roll call, please?

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

CHAIRMAN GALASSIE: The motion is strictly on the letter that was passed out, and the motion is to accept this letter and refer it to Staff for further review.

MS. OLSON: If we're referring it to Staff for further review, does it mean we're done with this?

CHAIRMAN GALASSIE: It does not.

MR. ROATE: Dr. Burden?

MR. BURDEN: Yes.

MR. ROATE: Mr. Eaker?

MR. EAKER: Yes.

MR. ROATE: Justice Greiman?

MR. GREIMAN: Yes.

MR. ROATE: Mr. Hayes?

MR. HAYES: Yes.

MR. ROATE: Mr. Hilgenbrink?

MR. HILGENBRINK: Yes.

MR. ROATE: Ms. Olson?

MS. OLSON: Yes.

MR. ROATE: Mr. Penn?

MR. PENN: Yes.

MR. ROATE: Mr. Sewell?

MR. SEWELL: Yes.

MR. ROATE: Chairman Galassie?

CHAIRMAN GALASSIE: Yes.

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

CHAIRMAN GALASSIE: Motion passes. Thank you very much. Now moving on, there was a suggested motion. Do you want to make that motion prior to the applicant's presentation?

MR. PENN: I would.

MS. AVERY: Can we hear of a timeline from Staff? What are we looking at? Because I know we moved this item to another agenda prior to, and we're under time constraints as far as from the date it was deemed complete.

MR. CONSTANTINO: We need to have initial consideration at this meeting.

MS. AVERY: So we can't defer?

MR. CONSTANTINO: It would require a Board deferral, in my opinion.

MR. URSO: Unless there is a Board deferral.

MR. CONSTANTINO: It would require a Board deferral, yes.

CHAIRMAN GALASSIE: Now you've confused me. Are we talking about the letter that was handed out, or are you talking about the agenda item?

MR. CONSTANTINO: The agenda item, sir.

CHAIRMAN GALASSIE: The Board has the right to approve this, defer it, reject it. So let me come back to my initial point to Member Penn. You are interested in making the motion?

MR. PENN: Yes, to defer this application.

CHAIRMAN GALASSIE: To defer this application, with any caveats or --

MR. PENN: Until we get Staff's analysis of this study from the University of Illinois College of Medicine.

CHAIRMAN GALASSIE: Okay. So the motion would be to defer this item pending Staff's response to the Board on the University of Illinois study. Does that motion get a second?

(Pause)

CHAIRMAN GALASSIE: Hearing none, motion fails for lack of a second. Thank you very much.

And I will now refer to the applicants for

your presentation, please.

MR. KNIERY: Thank you, Mr. Chairman. Good afternoon. My name is John Kniery. I'm consultant for the application. With us today to my right is Mr. Javon Bea. To my left is Mr. Rich Gruber. Also with us is Mr. Dan Colby, Vice-President; Linas Grikis, Legal Counsel; Charles Foley, CON consultant; Brad Turner, consultant; Mr. Sanford Stein, Legal Counsel; Mr. Tom Jenson, Marketing Director; Mr. David Kurtz, Vice-President; Mr. Joe Nemeth, CEOO of Mercy Care Insurance; Ms. Sue Ripsch, Vice-President; Mr. Ralph Topinka, Vice-President and General Counsel; Mr. Cook, CFO and VP; and Ms. Barb Bortner, VP of Marketing.

At this time, I would like to -- I have a couple of comments on the SAR, a couple of housekeeping items, potential corrections. On page 2 of the Executive Summary page, under "Conclusion", it is stated that the applicant does not meet State Board standard for construction and contingency costs. This item was corrected throughout the remainder of the SAR, but it should be noted that this applicant is in conformance with construction and contingency costs per square foot and that that cost is within and under the State norm.

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

going to stop you there. I'm going to apologize.

Could I get verification from Staff on that point?

MR. CONSTANTINO: That is correct.

CHAIRMAN GALASSIE: So we are in agreement?

MR. CONSTANTINO: Yes.

CHAIRMAN GALASSIE: Thank you very much.

MR. KNIERY: And I spoke to the Staff also. On page 15 of the State Agency Report, it stated that the estimated cost for the for a lesser scope and cost alternative was not provided. However, on page 115 of the original application as filed, the applicant identified the cost of approximately $115 million for this lesser cost and scope alternative.

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

CHAIRMAN GALASSIE: Thank you very much. So we are in agreement. Appreciate you pointing that out.

MR. KNIERY: I'd like for Mr. Bea to make some opening comments and for Mr. Gruber to be able to address specifically the State Agency Report.

CHAIRMAN GALASSIE: Please do.

MR. BEA: Thank you. My name is Javon Bea. I'm the President and CEO of Mercy Health Systems. We at Mercy appreciate your time and commitment to this process

of improving healthcare for the residents of the state of Illinois.

If I might, I'd just like to give you a little brief background on myself. I was born and raised in Rockford, Illinois. I attended a high school seminary in Crystal Lake. Then I graduated from Northern Illinois University with a Bachelor of Science, received a Masters in Physical Therapy from Mayo, Master's in Hospital Administration from the University of Minnesota, spent 9 years on the Senior Administrative Staff of the Mayo Clinic, three years as Chief Operating Officer with the Daughters of Charity National Health System, and 22 years now as the CEO of Mercy Health System, and I am now circling full back to my high school days, wanting to bring a hospital to Crystal Lake, Illinois.

Mercy is the proud sponsor for an application for a 128-bed hospital and physician medical center in Crystal Lake, a community of 160,000 people without a hospital and emergency services, and I'm not aware of any other community in the state of Illinois this large -- 160,000 people -- who doesn't have their own hospital and emergency service. The State of Illinois bed inventory in the Crystal Lake area does show a need for 8 ICU beds, which we would be fulfilling through this application. It

shows a need of 27 OB beds, which we would be filling 20 of those beds, and it does show a need of 83 medical/surgical beds. We are applying in our application for 100 medical/surgical beds, because the State CON application rules require that a minimum of 100 med/surg beds be applied for.

Within our application, we've clearly demonstrated there is a need for a hospital and emergency services in the Crystal Lake area and the surrounding areas of Cary, Algonquin, Lake in the Hills, and Fox River Grove, who currently don't have their own hospital. Our plan meets the needs of these communities in the most appropriate way by offering Mercy's integrated health system. Mercy has a unique, vertically-integrated health system, which means we've completely integrated and aligned our physician services with our hospital services and with our managed care services to provide outstanding quality patient care. As proof of this, three years ago, in 2008, the President of the United States recognized the quality of our organization and the patient care we deliver. In 2008, I was privileged to be honored in a ceremony in the Oval Office of the White House by the President of the United States and on behalf of Mercy received the prestigious Malcolm Baldridge Award, which is highest

quality award in the country and the highest award that can be given by the President of the United States. In 2008, mercy was the first vertically-integrated health system in the United States to have the entire health system be a recipient of this award, which means that our three hospitals, including Mercy Harvard Hospital in Harvard, Illinois and all of our physician hospitals in Illinois, were recipients of this prestigious award. In the 20-year history of the Malcolm Baldridge Quality Award, over twenty million requests, twenty million requests, for the Baldridge criteria have been downloaded from the United States Department of Commerce Malcolm Baldridge website, and there have been only 87 recipients in all categories of business, manufacturing, education, and healthcare. In the healthcare category, there has only been 12 recipients and only one vertically-integrated health system -- Mercy. So, Mercy is truly a leader in quality care and organizational excellence, according to United States Department of Commerce and the President of the United States.

(Recess due to technical difficulties of court reporter.)

CHAIRMAN GALASSIE: Folks, I think -- I was hoping to get through this agenda item, but to be quite frank with you, I think it's an appropriate time to break for lunch and we can do what we need to do technologically.

I have 11:35. We will reconvene this meeting following the break about 12:35. We should be back here about 20 after, 20 after 1:00.

(Lunch recess)

CHAIRMAN GALASSIE: Thank you very much for being timely. I will try to pull us back together here. We have a quorum. We're ready to go, and I believe we were just getting into your presentation. Now we have technology working again. Thank you very much.

MR. BEA: Did you want me to continue?

CHAIRMAN GALASSIE: Please. Thank you.

MR. BEA: I just wanted to thank you for the technical difficulty, because I don't know about you folks, but I was getting hungry.

Before the break, I had talked about my personal qualifications, and I was talking about the quality of Mercy Health System, and I don't think there is a lot more that needs to be said about the independent verification of Mercy's quality and organizational excellence than to be a recipient of the highest-quality award in the land. Just to say, except that to achieve that, we think there's been 20 million requests for the Baldridge criteria, out of every business in the country every form of business in 20 years, and have there only be

87 recipients, there's a reason for that, and that is because it requires a transformation to excellence from the housekeepers, dish washers, up to the neurosurgeons. And so all 64 of our facilities, our 4,000-plus staff members, our 400 doctors' offices all had to make that commitment to excellence, and that's what we want to bring with our hospital and physician medical center to crystal lake.

In our CON application, Mercy has chosen to locate its hospital and physician medical center in the most densely-populated area of McHenry County that suffers from excessive traffic congestion. Everyone knows the road infrastructure in Crystal Lake did not keep up with the copulation growth, which really restricts people's timely access to hospitals in further-away communities. The Crystal Lake area is also home to the most diverse population in McHenry County and has a growing geriatric population in need of additional services that are more accessible.

Accessibility is the key. We had testimony come up in the public comments about, "Well, this hospital is only, you know, here and there, and Sherman folks, 28 minutes away, or we're just so close and near." I've raised six children, and I've taken several of them, bleeding with gashes in their head, major cracked bones,

screaming in pain. I can tell you that 28 minutes and 14 miles would seem like an absolute eternity, not to speak of the people who got up in public testimony and talked about having to deliver their baby in the ambulances. And this idea from the ER physician that, "Boy, if the paramedics get there, everything is okay." I'm sorry, but I disagree greatly with that, because paramedics are not physicians, and a very common fall off a bicycle or on the ice -- a very common ailment is a subdural hematoma you get with breaking your little temporal bone. Minutes make the difference between being a vegetable or being totally normal if you can get to the ER within minutes and get the blood released. So, time, accessibility is the key and remember, we are putting our facility in the highest concentration of elderly and low income.

Our hospital is going to go into the highest concentration of low income in all of McHenry County, and it's very difficult when people talk about -- some of the folks getting up, "Well, they just kind of -- this out migration, et cetera". That's great if you've got the money, but when you look at the low income people, they may not even have a car. They talked -- they got up and talked at the public hearing about the barriers to transportation to get to these hospitals and emergency rooms outside of

McHenry County. So it's a vulnerable population that are in need of healthcare services that we are proposing to serve, and the point is we're going to place our hospital and medical center in the area with the highest concentration of low income and elderly that have these barriers and can't get to these facilities outside the area, outside of McHenry County or even inside of McHenry County.

Mercy is committed to serving the low income and elderly population, as proven by our hospital in Harvard, Illinois and the fact that we give over $38 million a year annually in charity care. But you only need to look at our track record of Harvard, and I want you to know that I sat before a previous CON Board, and I made a commitment to the CON Board, when this critical access hospital was closing, and Centegra's solution was close it down, and the CON Board gave me approval for Mercy to take over the ownership of this hospital that was going bankrupt, insolvent, and what we have done is fulfill our commitment to you folks. We put $20 million, added dozens of physicians and new services to serve what is up in that region the highest concentration of low income and has a large Immigrant population, farm workers, migrant farm workers in McHenry County. So we fulfilled our commitment

to you, the CON Board, in what we said we would do in Harvard.

I also want to say that this is unlike the other applicant that you're going to be hearing from, because the CON Board gave the other applicant approval for 20 OB beds, which they never finished the project and disappointed the people of Woodstock, Illinois that had counted on the 20-bed women's health center and never got it. So, I know that there's another application for a hospital in McHenry County, and I know that you're going to consider both applicants carefully. However, I just want you to know that we fulfilled our commitment to you, the CON Board, and we will again, if you approve our application to serve 160,000 people who don't have access to a hospital or emergency services.

The Crystal Lake location will also provide better access for emergency medical responders who presently face uncertainty about hospital bed availability, because of these other hospitals that got up and spoke about their record of emergency department bypass, and you can go back and see where newspapers have covered the volumes of bypassing that is going on, meaning that their beds are full so often that these ambulances drive to these hospitals and, because they are full, they have to send the

ambulance to even further hospitals, which jeopardize patients. Minutes count and could mean the difference between life and death. It's real cavalier to say, "We're here, we can take these ambulances" but we had too many people stand up and say -- there was a physician that stood up at the public hearing and said, "See this sign." He said, "This is what we get in the medical staff office, saying it's a red light sign. Red, we're filled, yellow, maybe -- excuse me. Red move on, keep sending the ambulances on, send the patients to another hospital. Yellow, a bed might come available. Green, we have beds." That's the first time in my 36 years in healthcare I had to hear about a system like that.

I'm going to say to you that these other hospitals got up here and talked out of pure vested interest. They would rather have people fight their way 14 miles, 28 minutes, to get access to an emergency room so that they can, just in their greed, not have to work on providing excellence of care and get them to choose. People who can get there will choose where they want to go, and they're going to choose on where they get the best, excellence in care. But what I'm trying to say to you is this is the highest concentration in the county of over 300,000 people that don't have that accessibility, the

highest concentration of low income and elderly.

The economic development impact of the project would generate an estimated 800 construction-related jobs. Within the first year of opening, Mercy Crystal Lake Hospital will employ more than a thousand individuals, of whom approximately 600 will be new jobs and join our current employee, Illinois family of 87 employed multi-specialty physicians and 450 employee partners. The total employment impact, which is important to Illinois, of Mercy Crystal Lake Hospital Medical Center grows from 1,000 initial jobs to 1,330 jobs within the first five years.

In addition to generating jobs and income, the economic activity associated with our project is going to generate tax revenue for the State of Illinois, for local governments. The physician medical center will be paying property taxes. The sales on our retail sales will be subject to sales taxes, but the income taxes alone on the 600-plus new jobs, 950 jobs within the first five years, will be generating millions of dollars of new income for the State of Illinois in income taxes alone.

So, in summary, we've located our hospital and physician medical center in an area of McHenry County that has 160,000 people without a hospital or emergency care and that has the highest concentration of poor and elderly

who -- accessibility is the key. That's the key issue, accessibility. When you're poor and you're elderly, trying to get to these places in a highly congested area, and you've got a kid who is bleeding, and you've got a sub -- that's a major problem. That's what we've had hundreds of people -- it became the subject of the last mayoral election, because the Mayor of Crystal Lake works for Centegra as Vice-President, and the people in Crystal Lake are so upset because they want a hospital, but he has a major conflict.

So, we're committed to begin this project immediately upon your approval and be operational to meet the healthcare community needs of these 160,000 people more than four years ahead of the Centegra project. In summary, Mercy has a nationally-awarded and proven track record of providing the highest quality of healthcare services to a unique and nationally-recognized, integrated health system that aligns physicians, hospitals and managed care delivery and what the current President of the United States is calling for in the Affordable Care Act, accountable healthcare organizations.

Mercy Health System, in the last month, May 2011 issue of "Inside Healthcare", is being described as a perfect prototype of the new accountable care organization

that's being called for in the Affordable Care Act. Mercy stands ready, upon your approval, to bring a hospital and emergency services to over 160,000 residents, and I just need to say that -- and I go back to the Centegra proposal, that employs the Mayor at Crystal Lake, who doesn't seem to want these thousand jobs in Crystal Lake or doesn't feel these 160,000 people need a hospital, that you're going to hear from Centegra shortly, proposing to put their hospital in Huntley, a southern part of McHenry County that has 26,000. People by choosing this affluent area, the rich area of Huntley, they're bypassing the area of greatest need of Crystal Lake, 160,000 people that don't have hospital emergency services and it has the highest concentration of low income and need. Centegra is speculating --

CHAIRMAN GALASSIE: I'd just ask you to keep your comments regarding Mercy's application.

MR. BEA: Sure. Whereas our application serves a current population need, without having to speculate or hope for future growth, because we have 160,000 people now who are in need of emergency services -- and I do need to say, Mr. Chairman, that if these beds are granted -- and it's been referred to already -- Centegra will have a monopoly of 95 percent of the beds in a county

of over 300,000 people. So there will not be competition for price. It will limit choices for healthcare workers and physicians.

We respectfully request your favorable approval, and my team and I stand ready to answer your questions regarding this very worthy project.

To begin that discussion, I've asked Rich Gruber, Mercy Vice-President, to briefly address a few questions that have been raised in the State Agency Report.

Thank you again.

MR. GRUBER: Mr. Chairman, Members, thank you very much for the opportunity to address our application.

With your permission, I'd like to spend a few minutes going through the specific deviations from the State norms that Staff was able to cite within our application. Before I begin that, though, I do want to express my appreciation to your Staff, who were exceptionally professional during the entire process of reviewing our application. When they requested additional information, we were able to provide that to them, and they are just incredibly professional, and we express our thanks to them.

CHAIRMAN GALASSIE: We thank you for that.

MR. GRUBER: Specific areas that were raised

in the SAR that I want to address is first "Reasonableness of Project Cost". This is 1120.41(c). I think it was noted at one point in time during your Staff presentation that our application is approximately 1.5 percent off of the State standard for architectural engineering fees. This is attributable directly to the method this project was put together. The applicant chose to proceed with an integrated project delivery system approach and is not only building a hospital but also an associated physicians clinic. This project delivery method requires much more up-front work and collaboration to ultimately provide a product that is the most reasonable to put together. In our mind's eye, we thought that the notice of trade-off with much lower construction costs due to the marginally higher architectural engineering fees would justify us being 1.5 percent over the State norm.

In the area of size of project, I would refer you to page 15 of the State Agency Report. Of the 18 departments the proposed project is to serve, we're only in non-compliance in two areas. Obstetrics is 23 gross square feet over the State norm. OB rooms, we will be all-inclusive of the patient stay, from admission to discharge, and the extra square footage will, frankly, allow patients and their family and support network to be

present throughout the entire stay. We believe that's well justified for the additional 23 gross square feet it represents per room.

The other area where we were found to be outside of the State norm was Phase 1 Recovery Station, where we're 81 square feet per station over the State norm. This allows for glass partitions for patient privacy and, frankly, patient confidentiality, and we hope you will take that into consideration as you review our project.

The combined, overall average represents less than one percent of the total hospital square footage. Thus, the proposed hospital project, we believe, is in substantial conformance with the criteria.

The next area I want to talk about very briefly is planning area need, and I want to thank David Carvalho for his explanation of the bed-need process and how it comes together and the discretion the Board has in that respect. It's very helpful information and, frankly, cleared up some issues in my mind. So, thank you, Mr. Carvalho.

The only area where a bed need is not met is in the medical/surgical area, and that's met -- not met my fewer than 20 beds, under the current State bed inventory. In fact, it's 17 beds, to be exact. The State has

calculated a need for Planning Area A-10 for 8 ICU beds, and we're meeting that particular need as identified by the State by proposing a project that includes 8 ICU beds. The State has calculated a bed need for 27 OB beds in the planning area A-10, and we're proposing to meet a portion of that need by proposing in our project to include 20 OB beds. Nobody has opposed our project as it relates to only OB or ICU. The State has calculated that there's currently a need for 83 med/surg beds in planning area A-10. We intend to meet that need as identified by the State by proposing 100 med/surgical beds, the minimum number required by Board Rules.

On that bed need, it has really fluctuated in McHenry County and has grown rapidly since 2002. The estimate in 2002 was that there was a 35-bed medical/surgical and pediatric bed shortage in McHenry County at that particular point in time. Between 2002 and 2008, the net increase in medical/surgical and pediatric beds increased 518 beds. By 2020, based upon population projections, the planning area A-10 need is going to be 131 medical/surgical and pediatric beds.

Different way to look at this in a slightly different perspective, State occupancy target for medical/surg facilities over 99 beds is 85 percent. So, 85

out of 100 beds are filled, and that's where you meet the State's optimum in terms of performance. What's being proposed by the applicant is, combined with the State's target occupancy of 85, you have a need for 83 currently. That's only a difference of two beds. That's only a difference of two beds. The need is substantially met by all three areas, med/surg, intensive care, and OB, at least in our mind's eye, within the application.

I want to address the issue of unnecessary duplication and service maldistribution. The Mercy project will promote the State Board's objective by aborting unnecessary duplication of services by first addressing medical/surgical, pediatric bed need in the planning area A-10 now and in the future. As I indicated previously, I've given you the estimates of what bed need will be in the future based upon the State's own numbers.

Second, we'll be providing primary and secondary hospital care. We're a project that's a general acute care hospital. We're offering community-based services to a local service area surrounding the facility. We're not providing tertiary care services. Work with area tertiary hospitals to coordinate transfer of patients requiring that level of care will be an ongoing venture on our particular part.

Third, physician need in McHenry County, and this is an important consideration, I believe, that you should think seriously of. As of January 1, 2011, Mercy Health System employed 76 full-time and 11 part-time physicians in northern Illinois, a major contribution of physician providers in that area. Mercy plans to add 45 additional positions in Crystal Lake, which, we believe, will assist in addressing the calculated physician need in McHenry County by nearly 50 physicians in March of 2010. That's a projection of a need of nearly physicians/specialists in McHenry County as of March 2010. These physicians will play a vital role in the future health of residents in McHenry County.

Mr. Chair, Members, in combination of these factors, we're confident that this project will not lower the utilization of other area providers below the occupancy standards specified by the Code. Further, our data and our projections indicate that this project will not lower to a further extent the utilization of other area hospitals that are currently -- at least during the last twelve-month period -- operating below the occupancy standards. How would we do that? First and foremost, we will be providing services to a large and growing area that is, frankly, under served physician, emergency and hospital services.

If you have our application in front of you, I direct your attention to page 103, 103 in the application. What you're going to find there is a dot matrix that demonstrates the population density across McHenry County, and what you'll see in the southeast corner of McHenry County is the greatest density of population within McHenry County as a whole. We believe that that's the right place to put our hospital at this particular point in time.

The other issue that we want to raise is the extensive out-migration of patients. From July 1, 2009 through June 30th, 2010, 53 percent of McHenry County residents received inpatient care outside the county and 22 percent at hospitals outside the Defined Service Area. During that same period, 70 percent of the residents from the immediate service area we're proposing to serve -- Crystal Lake, Algonquin, Lake in the Hills, and Cary -- received inpatient services outside the county and 21 percent in hospitals outside of the service area. The population growth in southern McHenry County and in southeast McHenry County will continue to drive the need for additional facilities. We've demonstrated that within our application. Mercy's track record, a proven track record, of providing higher quality, lower cost healthcare services by its integrated delivery service process will

greatly reduce out-migration from McHenry County, and the addition of the 45 multi-speciality physicians we propose bringing to the area will be an attractor to McHenry County residents to stay in the area as opposed to leaving the area for their needed services.

Physician shortages. Shortages of specialty physicians is one of the primary reasons that the residents of McHenry County are leaving the county in order to seek medical care elsewhere. We believe McHenry County has a deficit of physicians. This belief on our part is consistent with both the Council on Graduate Medical Education and the American Medical Association, which recognized a current physician shortage in the U.S. that will worsen over the next several years. The operational method utilized by the applicant, Mercy Health System, has been implemented effectively to recruit and retain needed physicians, thus helping reduce that out-migration of patients from McHenry County.

Finally, that particular critical area of service, I want to talk about Medicaid patients. In 2010, McHenry County's Healthy Community Analysis sites expanding numbers of Medicaid recipients within the county. In 2000, the year 2000, there were 6,293 residents on Medicaid, or 2.4 percent of the total population. By 2009, that same

report shows the number grew to 25,600 residents, or 8 percent of the population in less than 10 years, and most of that growth in Medicaid population occurred in the southeast and central portions of McHenry County, the very area where we have chosen to locate our facilities. By 2010, 30 percent of all Medicaid residents hospitalized from McHenry County will live in that southeast sub area that we are proposing to serve. All of these residents, many without access to good transportation, must travel outside the area for hospital care, because they do not have a local hospital facility available, and we propose to serve that population and specifically that population.

The next category of service where Staff found us to be deficient as it related to State norms is 1110.3030, Clinical Service Areas Other than Categories of Service. This criteria uses past physician referrals to project the ability of future utilization. The State Staff determined that since the historic referrals were derived from the planning area, that the utilization of the proposed hospital would have a negative effect on the existing facilities. Okay. What this criterion does not have is the ability to look at the applicant's capacity to bring in new physicians into the area, which will allow residents of McHenry County to stay home and receive their

healthcare close to home. Mercy has a plan to recruit physicians and provide much-needed services to the area, thus addressing that issue about migration. As previously discussed with respect to the impact of healthcare reform on demand, the growing patient population in McHenry County, Mercy's plan to reduce the chronic out-migration problem, et cetera, it is our belief that in the long run the area facilities will not be adversely affected by the proposed project. In fact, there are plenty of patients to share among all of us.

In conclusion, Mercy's approach to this application is in a way that looks at the Board's criteria all together and, conversely, we're not trying to pick and choose which criteria best fits our project. There are rules that, frankly, appear to be in conflict with each other which have influenced this applicant's decision in what to propose. The Certificate of Need process has many indicators of need. There is the utilization of area facilities, the ratio of bed to population, the only forward-looking indicator of need, your bed-need calculation. When applying the Board's rules, other indicators of need become apparent, such as the area of heavy patient out-migration and beds per thousand for this planning area compared to that of the state of Illinois and

the nation as a whole, a statistic I'll share with you.

In the state of Illinois and the nation as a whole, there's 2.6 hospital beds for every 1,000 population. In McHenry County, there is 1.0 hospital beds for every 1,000 members of population within that area. If you use that simply as a measure, you certainly have an opportunity to indicate that the bed availability within McHenry County is less than what is the norm, the average within the state of Illinois and the average on a nationwide basis.

Another indicator of overall need of area facilities that are closest to the proposed site, within 10 miles there are only three facilities, Centegra Woodstock, Advocate Good Shepherd and Centegra Hospital of McHenry. Combined these facilities' average occupancy is just at 84 percent, rounded. This equates to 2.9 beds potentially under utilized in accordance with the State's optimal occupancy level. In the entire 30-minute travel time contour, there initially appears to be potentially a 127 under utilized beds based on the 2009 IDPH Facility Profile on patient days, that are already two years old. However, when that -- when the beds that are not set up and staffed are subtracted out of the per facility profiles -- e.g. licensed beds versus staff and available beds -- when

they're subtracted out of the profile, the potential number of under utilized beds within 30 minutes is only 36, is only 36 out of an inventory that, you have to attest, is quite large.

Another area that would appear to present conflicting rules is the need to serve the planning area in a 30-minute contour. They can be in conflict. State Staff notes on page 20 of the State Agency Report that 83 percent of the expected patient volume is anticipated to come from the planning area. Furthermore, patient migration is normal to a degree, as all counties share borders. However, McHenry County, frankly, has the highest out-migration rate within the state of Illinois, and our project directly speaks to that issue and I hope bring those out-migrating patients back to their home for quality care close to home.

Again, I repeat, we've approached this application in a way that it looks at the Board's criteria all together and, conversely, we are not trying to pick and choose which criteria best fits our project. When all of the criteria are viewed together, they illustrate a formidable picture of need for this project, and we hope you will take that into account as you give every consideration to our application and hopefully move forward

with a project that, frankly, is the right project at the right time and the right place, serving the right population. We're serving 160,000 people today that don't have a hospital nearby and close by and an access issue that we've already demonstrated. We're not betting on the come. Our population is there today. It's not there 5 years from now or 10 years from today. It's there today and in need of service.

Thank you. We'll be happy to address questions.

CHAIRMAN GALASSIE: Thank you.

Staff, do we have any exceptions to the comments that were made there, referring to the report?

MR. CONSTANTINO: No, sir.

CHAIRMAN GALASSIE: Thank you very much.

I will open it up to the Board for any questions you might have.

MR. BURDEN: Mr. Chairman, I have a question for Mike.

On Table 5, Mercy Alliance, Inc. Safety Net Information, you expressed a charity care as a percentage of total net patient revenue. What about Medicaid? It's expressed in numbers of patients, and the data comes from Janesville. Where's the data from?

MR. GRUBER: This is data that is reported to the IDPH for our facilities in Illinois.

MR. BURDEN: Well, the facilities are.

MR. GRUBER: Mercy Harvard Hospital and our clinical facilities in the 14 communities where we have multi-specialty physician clinics who do provide Medicaid services as well as charity care.

MR. BURDEN: I'm pretty familiar with the area, having had a farm in that area for about 15 years, but this was back a few years ago. But I would like to have an expression of Medicaid percentage, the numbers. It's hard for me. We usually get it that way.

Mike, is there a reason why it's changed, or is it something that was more appropriate for your purposes?

MR. CONSTANTINO: Mercy Hospital -- Mercy Alliance only has one hospital in the state of Illinois, and that's Mercy in Harvard. What they provided us is information regarding their corporate parent and the Illinois facilities, as is reflected here. What you see in the profile information as a personal of total revenue is reference to individual hospitals.

MR. BURDEN: All right. I guess I'm a little confused about that. I certainly am aware of several other

outpatient facilities.

MR. CONSTANTINO: There are outpatient facilities. We have no jurisdiction over them.

MR. BURDEN: All right. Then this data is confusing to me personally, but then again I recognize the charity care data seems to be quite logical and reflect what might be appropriate. I just have a little problem with the numbers of patients as opposed to percentage of patients seen. Most of the time the data we see with hospitals in the past five years that I've been around here has been a reflection of total rather than total numbers of patients.

MR. CONSTANTINO: We can do that for these safety net --

MR. BURDEN: That's all right. I don't anticipate this being a game changer. I just have trouble understanding why the switch.

MR. CONSTANTINO: I'd be happy to provide that for you, Dr. Burden.

MR. EAKER: I would like to piggyback on basically that subject of charity care. As a non-profit hospital, for a new hospital, what percentage of charity care are you predicting you are willing to give from this hospital.

MR. GRUBER: I think that the best way to address your question and do it in a comprehensive fashion is to share with you our track record as a charity care provider within the state of Illinois and then --

MR. EAKER: I've heard that.

MR. GRUBER: -- and give you the promise we'll maintain that. It's always been our policy to provide excellent healthcare services to the people in every community where we serve, and that includes the proposed facility in Crystal Lake, regardless of their ability to pay. A couple of interesting things, as you put things into perspective from a charity care perspective, I note for you that charity care for our purposes, we begin measuring at 150 percent of poverty level. The other providers in the area measure it at 200 percent of poverty level, which gives you a little bit of an apples to oranges comparison, but, nonetheless, I think it's important to note that that is a commitment that we've made across our system and will continue to make here in Illinois and wherever else we have facilities. Let me --

MR. EAKER: If I might interrupt, to get specifically to my concern, throughout your presentations you've talked about strategically placing this hospital in an area where there is great need, where the poor people

are. I've heard that a lot. I'm simply asking, have you put a projection to what percent of charity care for this hospital you plan to give.

MR. GRUBER: We believe that the hospital charity care level will be at least as great as the charity care we provide at Mercy Harvard, in terms of a percent of revenue. For example, at Mercy Harvard, our charity care commitment for 2009 is at 1.5 percent of net revenue compared to .9 percent for Centegra McHenry, 1.3 percent for Centegra Woodstock and .6 percent for McHenry Centegra's specialty hospital in Woodstock. We're assuming at a minimum, through our commitment, we will be providing at least 1.6 percent of net patient revenues that will be allocated to a charity care category.

The important thing that you need to remember about Mercy Health System is something I'm incredibly proud to speak to. A fundamental part of our mission is our commitment to community. We do everything that we do driven on the basis of patient need, patient care, and part of that commitment -- and it's a huge part of that commitment -- is our commitment to that population that frankly is a fragile population. They're in need of those services.

MR. EAKER: I've heard that, and I just wanted

to know if you were willing to put a percentage projection to that.

MR. GRUBER: We're willing to commit to at least the level we provide -- and hopefully more than what we provide -- at Mercy Harvard, 1.5 percent, compared to.

MR. EAKER: All right.

MR. GRUBER: And that's net patient revenue.

MS. OLSON: So if I can keep going on this track, Table 5, is FY 10 a whole year? Because I see a decrease in charity care from '08 to '09 to '10.

MR. GRUBER: Let me explain that, and this is one of those that we grappled with. As we started pulling the information together to do this, what we discovered is we had an error in our calculation on the side of who we were actually counting. We were counting all applicants for community care or charity care assistance, all private pay patients. So what we tried to do is we culled the data to make it more reflective of what the reality was, and that's the hard number of charity care people that we were serving, and that's why you see the change, ma'am, in how the numbers are reported. We believe that FY 10 is probably the most accurate reflection we can possibly provide to you of our commitment.

MS. OLSON: Thank you.

MR. GRUBER: You're welcome.

CHAIRMAN GALASSIE: Other questions?

MR. HAYES: I was wondering if -- you know, your location is very close to the Wisconsin border, and do you ever look at the amount of patients that come down and serving patients from the Wisconsin area.

MR. GRUBER: You know, it's interesting. We have a commitment to serving McHenry County, and it's a commitment that is long-standing. We've been there a long time. What we've discovered is two things. First, there tends, first of all, to be an artificial barrier at the state line that would tend to preclude patients from coming across the state line to get services in Illinois, and the same is true conversely with Illinois patients going into Wisconsin. There just seems to be an artificial barrier. One of the other interesting observations, though -- and I think Mr. Nemeth spoke quite effectively to it earlier today -- is insurance products have a tendency to drive patients to where they are going to receive services, to a certain degree, and the inability of Mercy Care to be effective within McHenry County, not being able to contract with existing providers in McHenry County, has really precluded the ability to use insurance, at least, as a mechanism to point patients in a direction for services

elsewhere. The interesting thing, however, is irrespective of all of that being said, Mr. Vice-Chair, ultimately the decision is the patient and the physician's decision to make, and we believe in that and we support that.

CHAIRMAN GALASSIE: Member Penn, I believe, had a question.

MR. PENN: Yes, I did. I'm sure you're aware we accepted this document into our record.

MR. GRUBER: I am. I have not had an opportunity to review that document.

MR. PENN: That's what I was going to ask. Have you had a chance to look at this independent study from the University of Illinois College of Medicine? Have you had a chance to review this document? In the closing comment it says, "The independent study did not report the need for an additional hospital to be among healthcare priorities in McHenry County." So you have not seen this.

MR. GRUBER: No, we have not. We would hope to have that opportunity to review it at the appropriate time and do our own analysis and respond appropriately at the right moment.

MR. TURNER: And it's also important to have the background of who the residents were that were surveyed. Was a reasonable percentage low income or

elderly that are also sharing that perspective? Or is it people with good insurance that have a fine ability to find services and transportation to those services? We'd like to understand that background.

MR. PENN: I appreciate your comment, and that's why I asked it be referred back to Staff for further analysis as well. Thank you.

CHAIRMAN GALASSIE: Yes, David?

MR. CARVALHO: When all of the Board members are done with questions, I have some questions.

MR. EAKER: I would like to address a question and kind of phrase it like this or frame it like this: Supply-demand economics basically, in my limited understanding, is the more supply, the lower the price goes. I don't feel that that works in healthcare delivery, but do you have any way of addressing the fact that $200 million is going to lower the cost of getting procedures done?

MR. BEA: I just want to make an introductory comment, and then Rich may have a comment. That hypothesis has been put forward over the years. Except where you have one institution have a monopoly. As I said in my remarks, Centegra right now has 92 1/2 percent control over all beds in the entire county of 300,000. If they get the

additional beds they'll have 95 percent. That totally eliminates price competition. That eliminates the removal of any insurers to come in and compete. It really limits the freedom of healthcare workers. So, the issue is that Centegra is able to price -- outside of the normal Medicare, they're able to price in a way that they wouldn't be able to if there is any competition for them.

MR. GRUBER: With your permission, I'd like to amplify that just a little bit. As part of the public record for this, we retained the services of Dr. David Eisenstadt, who is a respected antitrust economist and former employee of the United States Department of Justice, the Antitrust Division and, frankly, he concluded in his study -- which is part of the record -- the improvement to competition from Mercy Crystal Lake Hospital and Medical Service, he concluded that greater competition usually benefits the consumer and the economy. He also concluded that the more competition there is, it normally fosters at least three beneficial effects, and it may be speaking directly to your issue, sir. It expands consumer choice, the provision of higher quality goods and services, and it lowers costs and prices. In his analysis, what he found was this bottom line that is really simple. After extensive analysis the additional competition in McHenry

County created by Mercy's proposed project, if approved, would result in price declines of up to 9 percent, thus improving the financial ability of the residents of McHenry County to obtain necessary healthcare services.

Conversely, he also concluded that the Centegra project, if approved, would result in a virtual monopoly for Centegra Health System, giving them for 436 out of 461 total beds in McHenry County or 94.6 percent, which, in turn, will lead to increased healthcare costs for the residents of McHenry County. So the choice is really kind of simple. Competition tends to breed expanded consumer choices, the provision of higher quality goods and services being provided, and lower cost in prices, and that, I believe, is part of the whole tenets of the Health Planning Act in the state of Illinois. Those are goals set forth in the very statutes within which you operate.

CHAIRMAN GALASSIE: Thank you.

Any questions by Board.

If not, Mr. Carvalho?

MR. CARVALHO: Thank you, Mr. Chair.

I'm trying to recall if Courtney and I were the only ones here the last time we had a bunch of new hospital applications.

MS. AVERY: Yes.

MR. CARVALHO: We were. With all of your applications, obviously it's important to hear all different perspectives on the information that is presented, but in the case of the new hospitals, which are such large investments of capital, for better or for worse the prior Board appreciated me asking questions that were skeptical, in order to get that information out. I'll see how that goes. So, let me ask some questions that are skeptical but for the purposes of illuminating the information, not indicating a Department preference one way or the other on the application.

Part of the reason why we wanted to make sure the inventory information was out there was because we wanted you to have an understanding of the strengths and weaknesses of the inventory. With respect to this particular application, let me recap the impact. The overstatement of population by 10 percent from what was really -- what is really there versus what was projected to be there has an impact, we estimate, of reducing the overall need from about the 289 beds down to 260, which would reduce the unmet need from 83 down to 54, roughly. You also should know that the -- as has been alluded, that 289 number is generated by looking at the service that people receive outside of the service area and taking that

into account, and the contribution to the total bed need for this region, due to that migration factor, as they call it, is about 64 beds. So, again, of the total 289 bed need in this planning area by our inventory, 64 beds of that need is attributable to persons receiving care outside of the planning area.

And the -- you know, the flip side, of course, is to the extent that you build in the planning area to address that need, tautologically those folks are getting their care outside of the planning area, so there's a flip side impact on the hospitals outside the planning area.

The issue of the impact of competition and the CON process is the inherent conflict of the CON process. Clearly, unlimited competition would involve most CON process. The Legislature has made a determination that there be a CON process. One of the impacts of that is that if you only allow construction where there's need, you do have an impact on the amount of competition. It has never been part of the process that you allow construction that doesn't meet your need criteria to foster competition. The whole point of the CON is to cap construction at need. So -- I mean, the Legislature has made that determination that the CON process -- that we're a CON state.

In the past in these types of applications,

we've also heard the utilization factor is calculated based on licensed beds versus staffed beds and, therefore, tends to overstate the lack of utilization, because if you're dividing by a larger number, you're making a smaller result, and so if it's something that looks like it's 50 percent utilized but many of the beds aren't staffed, then the beds that are staffed are being utilized at 60 percent or 70 percent. But that argument overlooks the fact that the unstaffed beds are, nonetheless, allowable beds and you have authorized them to be staffed. At such time as the demand is sufficient to staff them, they would be staffed. So, in the absence of taking away those unstaffed beds, allowing additional beds to be filled because there are unstaffed beds elsewhere actually contributes to the over supply. It doesn't work the other direction.

The issue of the 100 bed size was an issue four or five years ago, actually, for applications, I believe, in this region, and the point is you have adopted a rule that says you don't want to see a hospital built until the unmet need is 100, and back then, you also got applicants saying, "Well, we're almost at 100, so let us build." The point of the rule was wait until the need is 100 and then do the application, not do the application before the need is 100 and then say, "Well, please overlook

the fact that we're not 100."

The safety net -- I apologize for not speaking earlier when Mr. Penn had made the motion on the safety net response. I had been under the impression that our Staff had reviewed the materials that were supplied as part of the safety net response but it simply neglected to include their description in the State Agency Report. In fact, we have not reviewed it, and so I do need you to know that we have not reviewed that. So, the information that has been alluded to in the safety net response, which presents another perspective on whether there is an impact on the safety net -- namely the perspective of other providers and the entity that did the study -- has not been reviewed by us, and so we can't make any statement to you as to whether it's accurate or not.

In the past, there has also been the issue about access and access to ER's and access to services and, again, it's a balance view to draw, because the logical conclusion, you'd have a hospital on every block if everybody is expected to walk to their hospital and have access. So, clearly, somewhere in between the access that exists and the access that you would like to see is the reasonable position.

And, finally, on the issue of charity care,

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

persons who may need specialty referral or other kind of care that isn't typically provided in an emergency room because of EMTALA obligations. So, in fact, sometimes I started referring to it as uncompensated indigent care as opposed to charity care, because there is really no charitable impulse. It's just uncompensated, unsponsored care provided as a cost of doing business.

So, that goes through a list of observations and benefit of the history of this. Just so you know, the Board has considered perhaps 8, 10 applications for new hospitals over the last 8 years and approved one in Bolingbrook and denied the others. But many of these issues I raise today were part of the dialogue back then, so I wanted to raise them today to inform you of those issues. I'll stop there.

CHAIRMAN GALASSIE: Thank you, David.

Any other questions on the part of Board members? I have attempted to be very gracious of the time committed to this item because of the significance involved in it. Does the Board --

MR. HILGENBRINK: Mr. Chairman, I'd like to ask a question on the cost, construction cost. Has anything been built into the cost of construction to address ongoing operational cost? Is it a -- in terms of,

for example, lead design building or something with sustainability to address those kind of operational costs.

MR. GRUBER: Let me address this in this fashion: This is a project that has been on the Mercy books for 7 years, waiting for that right moment to come forward to serve the residents of Crystal Lake, Cary, Algonquin and Lake in the Hills. We've owned the land that we propose to build on for quite a number of years. We have had ongoing planning activities, ongoing architectural activities associated with this project for so long that they've become part of a routine operating expense with how we handle our Mercy budgetary issues. So, you don't see those numbers appear in this project. The project numbers that you see are the costs of performing the project.

Does that address your question, sir?

MR. HILGENBRINK: Not really.

MR. BEA: I guess maybe this will be -- but I think history -- instead of our opinion, history is a better guide going forward, and in our report, you'll see that Mercy is one of the few systems in the country that during the financial collapse of '08, '09 and '10, that even though -- that continued to be extremely stable in every turn in operations because of our efficiency. That's how the Baldridge Award came in versus other hospitals were

relying on income from reserves and, of course, they lost that income from reserves when the market crashed. We lost income from our reserves when the market crashed, but we have an amazing stability track record. I mean, the people that have looked at this have said, "Wow, that's amazing". And I go back to the integration between our physicians and our hospital that has allowed us to maintain that kind of efficiency.

But there are three or four questions earlier about charity care, and something that is very important -- and Mr. Carvalho is correct, hospitals are required by EMTALA to give charity care in the ER. Physicians aren't required to give charity care. Something that we do with all 400 of our doctors, the 87 physicians in Illinois, growing to 132 physicians, is that our physicians take all comers, all comers without ability to pay in the doctor's offices. That is true charity care. There is no EMTALA law, nothing requiring Mercy to provide charity care to people walking in their offices, and the reason the doctors take all is they still get paid by Mercy for providing the service, even though Mercy is not getting paid. I hope you're following that, but it doesn't get any better than that, because people are going to doctors' offices, quite frankly, before they ever show up at the hospital. But

when they see a sign on the wall "Charity care not welcome", "Medicaid not welcome" -- that's what you have here today, and a lot of it has to do with economics of healthcare, et cetera. We wouldn't have to do that but we do that with all 400 of our doctors. They open their doors to charity care because we are still paying them.

And then the last comment I would like to make is, there is a reason there is unstaffed beds in the same community oftentimes where there are hospitals that don't have unstaffed beds, and that's because of patient and doctors' perceptions of the lack of patient care and the lack of quality offered at those hospitals.

Thank you.

CHAIRMAN GALASSIE: Did you get an answer to your question.

MR. HILGENBRINK: I got the information.

MR. GRUBER: Let me try one more time. There are no operational costs included in our project, none whatsoever. Does that get at the heart of your question, sir?

MR. HILGENBRINK: Thank you.

MR. GRUBER: Thank you very much.

CHAIRMAN GALASSIE: Member Penn?

MR. PENN: By statute, this Board has the

authority to impose fines on this project if they do not complete this project on time, and it's always a concern for me. We look at you as being our clients. I'm not comfortable imposing fines. So, my question is, have you built in any type of liquidation damages to your construction contract, that if this thing is not completed on time, that the responsibility falls back on the contractor and not the hospital.

MR. GRUBER: It's our anticipation that, barring any litigation, we will meet the project time frame that we've proposed within the application and we'll meet it a hundred percent and we'll meet it within budget, and we'll be pleased to come back and report to this Board that, in fact, we've accomplished that objective. In terms of penalty or particular interests that we would charge back against a contractor who would be derelict in not providing full and complete services, that is something that we would certainly take a very hard and fast look at if that would be a consideration that would cause you to support this project, sir.

MR. PENN: Well, for each applicant that comes forward, it's a common question I ask, if you built in some type of protection, some type of safeguard, safety net where you are going to absorb the cost of the fine that can

be passed to the contractor who did not complete his project on time.

MR. BEA: It's a great recommendation, and we'll do it. We need to know that we have approval, but I love your recommendation, and we'll provide you proof that we did it. We'll be taking bids for contractors, and we'll make that a requirement, no problem, and it's a great suggestion, and we can come back and prove to you that we did that.

CHAIRMAN GALASSIE: I'm going to ask that the Board be comfortable in moving forward and following this question for a vote on this subject.

MS. OLSON: I just want to be sure that it's your position, despite all of the other testimony we've heard from all of the other hospitals in the area, that your project is not going to negatively impact those other health systems.

MR. BEA: It will not and, furthermore, the citizens of Crystal Lake will back that up.

CHAIRMAN GALASSIE: I would like to remind Members that you have an opportunity to vote in the affirmative, you have an opportunity to vote in the negative, you can recommend that this be deferred and/or contingency, as I think Mr. Penn was suggesting, if it were

to move forward on this item. I think we've had ample dialogue, and I ask that we move forward on this project with a vote. As Frank reminds me, if you vote in the negative, if you vote no, please, for the record, state a reason why you are voting no. Thank you very much.

I would entertain a motion to approve Project 10-089 to establish a 128-bed hospital in Crystal Lake, Illinois at the cost of approximately $2 million -- $200 million. That was a bargain. I need a motion.

MR. GREIMAN: So move.

CHAIRMAN GALASSIE: There is a motion. Is there a second?

MR. BURDEN: Second.

CHAIRMAN GALASSIE: There is a motion and second.

If I may ask, does Member Penn want an amendment to that? Do you want a contingency on this, is what I'm suggesting?

MR. PENN: No. thank you.

CHAIRMAN GALASSIE: Thank you.

There is a motion and a second on the floor. I'll ask for a roll call vote.

MR. ROATE: Motion to approve Project 10-089, motion made by Justice Greiman, seconded by Dr. Burden.

Dr. Burden?

MR. BURDEN: After a lengthy discussion, I'm impressed with the diligence and the information that's been provided by the applicant. They've worked diligently. I have to comment, having been on this staff of Mercy Hospital in Chicago, I'm very familiar with -- nothing to do with Mercy Alliance, but I'm impressed how Sister Sheila runs a safety net hospital with 38 percent Medicaid, and that's part of the reason I asked questions about how you handle it. It's a totally different patient demographic, I understand that. I'm also very concerned when I see occupancy rates in competing institutions be so low. I am disappointed to see Sherman Hospital be as low as it is, but I feel that, in my judgment at this moment, I would have to vote no because of the reasons I've suggested. I would anticipate listening to the Center for Comprehensive Health Planning, when it exists more functionally, for their input to help us make wiser decisions all the way down the line. One new hospital in 30 years is the track record. I vote, no but that shouldn't be terribly shocking?

MR. ROATE: Mr. Eaker?

MR. EAKER: I have many doubts. You hinged a lot of your presentation on the need for low income care

and that's the strategic place for that. I find 1.5 percent to be a very low amount for true charity care. So it kind of comes down to believability. I vote no.

CHAIRMAN GALASSIE: Justice Greiman?

MR. GREIMAN: I vote aye. Just my own observation, that we don't tell McDonald's you can't go in there because there's a Taco Bell there. So I'm going to vote aye.

MR. ROATE: Mr. Hayes.

MR. GREIMAN: And I think the presentation was very well done.

MR. ROATE: Mr. Hayes?

MR. HAYES: I'd like to compliment the applicant of the thoroughness of the application, as well as their presentation, and I'd also like to compliment the opposition that we have heard and the opposition that was expressed at the public hearing. My concern here is that the requested beds are in excess of the calculated need that is described in the State Agency Report, and there are existing facilities in the planning area operating below the targeted occupancy. There are existing facilities within a 30-minute, operating below the State Board's target, and also the physician referrals that were submitted by the applicants for the proposed project will

lessen the utilization of existing providers. I think with healthcare reform and the state of the economy, as well as the demographics that have come in from the census here, and ultimately that will -- through all this process, that will lead to a decline in the calculated bed need ultimately. So, I'm going to vote no.

MR. ROATE: Mr. Hilgenbrink?

MR. HILGENBRINK: I'm going to have to vote no based on not meeting the criteria and convincing me that they have overcome those objections.

MR. ROATE: Ms. Olson?

MS. OLSON: I vote no for the same reasons that Vice Chairman Hayes just eloquently outlined.

MR. ROATE: Mr. Penn?

MR. PENN: I am voting no based on what I think will be a negative impact on the planning region, and also giving the Staff a chance to review this independent study from the University of Illinois. That's why I was hoping to defer this and not bring this to a no vote, but I'm voting no.

MR. ROATE: Mr. Sewell.

MR. SEWELL: I vote no. There doesn't appear to be a need for the beds, and even with the uncertainty we've heard with the population projections, it looks like

it would have a negative impact on existing hospitals.

MR. ROATE: Chairman Galassie?

CHAIRMAN GALASSIE: The chair votes no at this time with comments previously made and at the same time would like to commend Mercy's commitment to the community. It's very clear it is significant.

MR. ROATE: That's one vote in the positive, eight votes in the negative.

CHAIRMAN GALASSIE: Motion does not pass.

MR. URSO: You'll receive an Intent to Deny. You have another opportunity to come before the Board. You also have an opportunity to submit additional information.

Thank you.

CHAIRMAN GALASSIE: Thank you. Good luck to you in the future.

We have another significant item on the agenda following, and I will be making a recommendation for agenda items following 090, that if there is no opposition by Staff or any public opposition, that your presentation -- the briefer the better, to be quite honest.

Does the Board feel the need for a 10-minute stretch? Let's take a 10-minute stretch. We will pull it back at quarter to three.

(Recess)