1 MS. MARTIN: And that was the best
2 alternative. When we look at patient care, which
3 hospitals are about, that's . . . so, you know,
4 it is what it is.
5 CHAIRMAN LOPATKA: Okay.
6 SECRETARY MARK: Thank you.
7 CHAIRMAN LOPATKA: We will have a
8 short break of 5 or 10 minutes, and then we will
9 hear our last Applicant of the day.
10 (Whereupon, a recess was had at
11 3:36 p.m., after which the
12 proceedings were resumed at
13 3:47 p.m. as follows:)
14 CHAIRMAN LOPATKA: I believe that
15 everyone has returned to the Board table, so we
16 are going to hear our last Applicant, our final
17 subsequent-to-intent-to-deny, Edward Plainfield
18 Hospital, to establish a new 130-bed acute care
19 Hospital in Plainfield.
20 And the directions that I gave to the
21 Applicant just prior to you, please focus on the
22 new information that you have submitted since
23 your last appearance before the Board and the
24 negatives that are in the State agency report.

1 If you would identify yourselves and be
2 sworn, please.
3 DR. KAPLAN: Sure. I am Alan Kaplan.
4 I am the project lead. To my right is Mark
5 Silberman, legal counsel, and, to my left,
6 Annette Kenney, vice president of network
7 development for Edward.
8 THE COURT REPORTER: Would you raise
9 your right hands, please.
10 (The witnesses were thereupon
11 duly sworn.)
12 THE COURT REPORTER: Thank you. And
13 please print your names.
14 CHAIRMAN LOPATKA: Mr. Roate, may we
15 have the State agency report, please.
16 MR. ROATE: Thank you, Madam Chair.
17 The Applicants are Edward Health Services
18 Corporation, Edward Health Ventures, and Edward
19 Plainfield Hospital.
20 The Applicants propose to establish a new
21 130-bed acute care hospital in Plainfield. The
22 facility will have 375,585 gross square feet of
23 space, and the total estimated project cost is
24 $241,538,000.

1 Thank you, Madam Chair.
2 CHAIRMAN LOPATKA: Sir.
3 MR. URSO: Madam Chair, I just need
4 to --
5 CHAIRMAN LOPATKA: Oh, that's right,
6 Mr. Urso. Sorry.
7 MR. URSO: If I can have your
8 indulgence for two minutes, I do need to inform
9 the Board that we do have an outstanding
10 compliance issue with this Applicant, Edward
11 Hospital, and it has to do with Docket No. 04-43,
12 and it has to do with the Edward Plainfield
13 Surgery Center for failure to complete on time
14 and become licensed on time.
15 And I also want to note that settlement
16 discussions are pending and we're hopeful that we
17 can resolve this matter shortly.
18 Thank you.
19 CHAIRMAN LOPATKA: Thank you.
20 Dr. Kaplan.
21 DR. KAPLAN: Thank you.
22 Madam Chair and members of the Board, we
23 have modified this application in response to
24 comments and concerns articulated by the Board.

1 We believe these modifications result in a much
2 improved, community-focused application.
3 We have increased OB beds from 22 to 32.
4 Our original application included an ob-gyn
5 clinic geared toward lower-income patients. This
6 is the fastest-growing segment of the Medicaid
7 patients in the area with a total of 1,558 births
8 in 2008 and a growth rate of 17 percent over the
9 past three years. We have since added outpatient
10 programming to include perinatal services for
11 high-risk pregnancies, cancer screening,
12 neurogynecology services, a thoracic program, an
13 extension of our care clinic, which serves the
14 needs of sexually abused children.
15 I will mention that our care clinic is
16 already the sole provider for these services in
17 Planning Area A-13.
18 We have decreased medical/surgical beds
19 from 116 beds to 72 beds. We still believe the
20 ultimate bed need will be closer to the original
21 116 beds, but we have dropped to 72 beds as a
22 compromise to come closer to the bed-need numbers
23 developed by the State.
24 We have not changed our commitment to

1 provide 20 acute mental illness beds. Overall,
2 we have reduced the size of our project from the
3 original 162 beds to 130.
4 At the last meeting Board members indicated
5 that there appeared to be conflicting and
6 confusing data surrounding this project. In
7 direct response we submitted a document dated
8 September 10th to provide clarification.
9 If we were only allowed to make one
10 compelling argument for improved access, here is
11 what it would be: More people leave Planning
12 Area A-13 for hospital care than any other
13 planning area in the state. The population in
14 Planning Area A-13 is about 800,000 individuals.
15 A full 50 percent of inpatient care generated
16 from a population of 800,000 residents occurs
17 outside the planning area. Think about that.
18 The magnitude of this number is
19 astonishing. It accounts for more than
20 300 medical/surgical beds being occupied outside
21 of the planning area in any given day, not to
22 mention OB and acute mental illness beds.
23 A full 25 percent of that outmigration
24 already comes to Edward Hospital in Naperville.

1 Every day 100 Edward beds are filled with
2 patients from this planning area. We are over
3 30 minutes away. The burden of travel of these
4 patients, their family, and their friends
5 continues to increase as traffic congestion
6 worsens. There is no public transportation in
7 this area. This project will greatly improve
8 access for these patients.
9 The inadequacy of hospital services in
10 Planning Area A-13 is further supported by the
11 following: The IDPH inventory calculates a need
12 for 76 OB beds. It calculates a need for
13 40 med/surg beds and 24 acute mental illness beds
14 within the State's planning horizon. That's a
15 total of 140 beds within two years of this
16 hospital opening.
17 The capacity to treat ICU patients is being
18 stretched, yet what is the number one reason for
19 hospitals going on bypass? Lack of ICU capacity
20 during volume surges, such as flu epidemics.
21 Using State utilization standards in
22 Table 1 of the SAR, 9 of the 12 hospitals with
23 utilization data available and identified as
24 being within 45 minutes exceed IDPH occupancy

1 targets for ICU in 2007.
2 In fact, using IDPH target occupancy, there
3 are only two open ICU beds within 30 minutes.
4 These numbers are taken from the IDPH profiles.
5 The limited bed capacity is further
6 evidenced by the recently released State data
7 attached to the SAR. Copley's 2007 utilization
8 calculation includes 26 medical/surgical beds
9 that were under construction. If we correct the
10 figures for these beds being unavailable, their
11 actual utilization level was 97 percent, not
12 75 percent.
13 We looked at this many different ways. We
14 considered multiple tests of need. No matter how
15 we sliced it, we consistently came to the same
16 conclusion: This hospital's needed to improve
17 access to care. There is an overwhelming public
18 testimony -- there is overwhelming public
19 testimony from residents, county and local
20 officials, and independent experts attesting to
21 the need for a hospital in this area.
22 In regards to low-income public sector
23 patients, the Will County Health Department and
24 the local chapters of the National Alliance on

1 Mental Illness have submitted written testimony
2 regarding the need for inpatient psychiatric
3 services in this area.
4 The only opposition has come from competing
5 hospitals. We address all their claims in our
6 November 25th submission. However, I would like
7 to touch on two items: First, the Bolingbrook
8 Hospital and, second, the impact of the economy
9 on the housing market.
10 In regards to the Bolingbrook Hospital, all
11 their beds are included in the IDPH bed-need
12 calculations. Bolingbrook Hospital is on record
13 acknowledging they will not have enough beds to
14 service the area, and this is consistent with all
15 the available data in the IDPH calculations.
16 Bolingbrook Hospital elected not to provide
17 acute mental illness beds. As the Board may be
18 aware, the Adventist system recently filed an
19 application to discontinue their AMI service at
20 Hinsdale Hospital. That application was
21 withdrawn only after we pointed out their intent.
22 Despite all the indications of need,
23 Bolingbrook Hospital argues that the Plainfield
24 Hospital, which won't open for four years, should

1 not be approved because their hospital currently
2 has capacity.
3 There are two reasons why this is not a
4 valid argument: First, they have only been open
5 one year. It takes time to ramp up. According
6 to self-reported data to the Metropolitan Chicago
7 Hospital Council, they continue to grow. They
8 have only recently been approved for cardiac
9 catheterization services, which should boost
10 their census.
11 Second, the most important invalidation is
12 related to the anecdotal story brought forth
13 yesterday by Madam Chair, a patient who could not
14 go to Bolingbrook Hospital for insurance reasons.
15 Bolingbrook Hospital has a restrictive policy
16 that thwarts its own growth.
17 CHAIRMAN LOPATKA: Well, no, that's
18 not correct. It's not that they're restricted;
19 it's her insurance is restricting her.
20 DR. KAPLAN: Correct. And I'm going
21 to -- this will lead right to that.
22 CHAIRMAN LOPATKA: Okay.
23 DR. KAPLAN: Bolingbrook Hospital has
24 a restrictive policy -- a medical staff policy --

1 that restricts any physician from joining their
2 staff if that physician owns ancillary services
3 within 7.5 miles of the hospital. This policy
4 specifically includes cardiac diagnostics,
5 surgical centers, and imaging and laboratory
6 services. This policy excludes a very large
7 number of high-quality, busy, progressive
8 physicians.
9 So if a patient belongs to an HMO, he or
10 she is assigned to a physician. The patient must
11 go to a hospital where that physician has
12 privileges or the care may not be covered.
13 Bolingbrook Hospital's restrictive medical staff
14 policy restricts patient access.
15 Edward contracts with all major insurers.
16 We have an open medical staff policy that is
17 based on board certification and quality, not
18 business affiliations.
19 Why should our project be penalized based
20 on Bolingbrook's current utilization one year
21 after they open, negatively impacted by their own
22 restrictive policy and four years before the
23 Plainfield Hospital would open, especially when
24 we can fill our modestly sized Plainfield

1 Hospital with patients we already see today in
2 Naperville?
3 Now let's turn our attention to the
4 economic downturn, and it was brought close to
5 home yesterday when we all witnessed the huge
6 lines for jobs at the job fair next door. We
7 need to remember that economies are cyclical and,
8 although we don't know when it will turn around,
9 no one is predicting that this will last forever.
10 Dr. Burden, in response to your question
11 yesterday, I don't know where St. Joe's got their
12 housing-start statistics, so I can't refute or
13 validate the statistics; however, whether or not
14 the housing starts are down 80 percent, as
15 St. Joe's contends, St. Joe's is also
16 acknowledging, if you reverse that statistic by
17 their own admission, that new housing starts in
18 the area are continuing, and we concur, they are
19 continuing, at least -- according to their
20 statistics -- minimally at a rate of 15 percent
21 but coming off a very high starting number.
22 Remember, this is amongst the
23 fastest-growing areas in the state and the
24 country. Will County is poised for a resurgence

1 of its rapid growth as the economy rebounds, and
2 there is reason to believe that Will County may
3 lead the way.
4 Aside from providing a good standard of
5 living and some of the most affordable housing in
6 the Chicago suburbs, Will County is emerging as
7 the leading global railway transportation center
8 for the Midwest. Minority Leader Tom Cross,
9 Will County Executive Larry Walsh, and Will
10 County Board Member Lee Ann Goodson have all
11 submitted testimony regarding a $2 billion
12 investment in a railway project that is projected
13 to create more than 15,000 new jobs in this area.
14 Even this hospital project would go a long way to
15 creating jobs and stimulating economic recovery.
16 One more point regarding housing starts:
17 This statistic does not directly correlate to
18 hospital utilization. There are other factors,
19 such as birth rates and aging demographics.
20 Despite the economy, overall inpatient
21 utilization in Planning Area A-13 hospitals
22 increased 4.6 percent from 2007 to 2008.
23 At this point I will turn the microphone
24 over to Mr. Silberman, who will very briefly

1 address an important issue that has been
2 discussed by the Board.
3 MR. SILBERMAN: Thank you, Madam
4 Chair, members of the Board.
5 I'd just like to add a few comments in
6 direct response to some of the issues that were
7 raised at our last Planning Board hearing,
8 specifically related to the question of the
9 100-bed rule and to this Board's discretion.
10 In August there was an acknowledgment that
11 this looked like a good project but that there
12 were some concerns that it didn't meet all of the
13 established criteria.
14 In reality, almost no project has positive
15 findings on all criteria, but, moreover, since
16 there's been an important discussion about
17 polling this Board's rules, the Board's rules do
18 not provide that a project is required to meet
19 all of the criteria.
20 And I will quote directly from the rules,
21 Section 1130 --
22 CHAIRMAN LOPATKA: I think we
23 understand that, Mr. Silberman, that there are
24 multiple tests of need. I don't think we need a

1 lecture on the Board's rules. I'm -- that's my
2 opinion. Maybe my fellow Board members feel
3 differently about it.
4 But we understand that, and it's a rare
5 occurrence when everybody is in full compliance.
6 I think we've had 1 application out of
7 30-something this time, and I could count on less
8 than one hand the number in a year.
9 So I'm -- I'm not sure that . . . I think
10 we understand the point that you want to make.
11 MR. SILBERMAN: And I -- the only --
12 then I won't -- I won't cite the rule, but what I
13 will just acknowledge is that no formula is
14 provided, no one criteria is ranked above the
15 other, and there's no single criterion that any
16 application must meet in order to get approved.
17 Now, this Board designed -- Illinois
18 designed a Board that would utilize its
19 discretion and foresight to plan for the health
20 care needs of Illinois residents. In the past
21 discussions regarding this project, the Board has
22 discussed the 100-bed rule for the establishment
23 of a new hospital as if this were a requirement
24 for a project to be approved, but we know that

1 that's --

2 CHAIRMAN LOPATKA: That is the rule

3 for a hospital within a metropolitan statistical

4 area.

5 MR. SILBERMAN: Well, and -- if I

6 may, it is a rule, but there is no -- there is no

7 requirement that that criteria be set above any

8 else, and I think it's important to understand

9 the history of this rule.

10 Historically, this rule had focused on the

11 number of beds across all categories of service,

12 but it was in 1996 that this criteria changed to

13 require 100 medical/surgical beds, and a lot has

14 happened since then. In 19 --

15 CHAIRMAN LOPATKA: Mr. Silberman --

16 SECRETARY MARK: Mr. Silberman, is

17 this information already contained in the

18 application?

19 MR. SILBERMAN: This is all

20 information and this is all in the supplemental

21 material we've provided since then, yes.

22 CHAIRMAN LOPATKA: Well, I -- sir, I

23 have reviewed the application very thoroughly.

24 I mean, I feel like you're subjecting me to a

1 lecture. I think, after 4 1/2 years on this
2 Board, that I understand the process of that --
3 you know, of the rules. You know, so you don't
4 need to go into it for my benefit.
5 I don't know how my other Board members
6 feel.
7 MEMBER AVERY: I don't think for
8 ours, either.
9 CHAIRMAN LOPATKA: Okay. So -- I
10 mean, I'm hearing from other Board members that
11 this is not terribly productive.
12 MEMBER PENN: I would like to hear
13 what you have to say.
14 CHAIRMAN LOPATKA: Okay.
15 MEMBER PENN: I'm just one Board
16 member, but --
17 CHAIRMAN LOPATKA: Okay. But you're
18 the newest Board member so, you know . . .
19 MEMBER PENN: Yes.
20 MR. SILBERMAN: So -- in 1996 the
21 average patient length of stay for Planning
22 Area A-13 was 5.89 days. Today this average
23 patient's length of stay in Planning Area A-13
24 has reduced to 4.2 days.

1 This reflects a 28 percent decrease in the
2 average length of a patient's stay, which means
3 that the amount of patient care that was
4 reflected by 100 beds in 1996 now only requires
5 72 beds to provide the exact same amount of care.
6 It means that in 1996 where 100 beds were needed
7 today we only need 72 to provide that same care.
8 This Board has approved hospitals in --
9 that have flourished in MSAs despite having less
10 than 100 medical/surgical beds. This Board heard
11 an application involving Lake County, which has
12 two hospitals that have fewer than 100 authorized
13 medical/surgical beds and has a third hospital
14 that has fewer than 100 authorized medical/
15 surgical beds. Morris Hospital, which services
16 Plainfield --
17 CHAIRMAN LOPATKA: Sir -- sir, you
18 made this point at the last appearance, and --
19 you know, some of these hospitals are critical
20 access hospitals. Certainly, our current Board
21 has never -- and I don't believe within the last
22 number of years -- you know, you're making a
23 point that you made at the last appearance, and
24 it's in the record, in the transcript.

1 Because you mentioned these identical
2 hospitals at -- at the last meeting, so . . . I
3 mean, if you're trying to get this on the record,
4 it's already on the record because it's in the
5 materials from your prior appearance.
6 MR. SILBERMAN: I'll move on, then.
7 CHAIRMAN LOPATKA: Okay.
8 MR. SILBERMAN: In August the
9 argument was put forth that this Board should
10 wait for the need of 40 medical/surgical beds to
11 grow until it was a need for a hundred
12 medical/surgical beds.
13 And we would reiterate that, in deciding
14 the discretion that should be used, that we ask
15 this Board to consider how apart the Board's own
16 assessment of need is from the project now as
17 modified. The difference between the need and
18 the project as modified is the equivalent of
19 one nursing unit. This is one nursing unit in a
20 planning area that encompasses two huge counties,
21 over 800,000 people and over 1250 square miles.
22 We'd ask, is that substantial enough to
23 deny this community improved access to health
24 care?

1 In summary, we have never swayed from our
2 belief that the needs of this community will
3 exceed the Board's own projection of need, but
4 we'd ask you to consider the impact of this
5 decision using the Board's own determination of
6 need, that, if approved, this hospital will have
7 stepped up to meet the growing mental health
8 need, which is only growing because many acute
9 care hospitals in this area are either
10 discontinuing that service or not providing that
11 service.
12 This hospital will have established the
13 single-largest OB unit in the area and will have
14 implemented multiple programs to improve health
15 care for women with specific programming that is
16 designed to ensure improved access to health care
17 for low-income women. And, if denied, we know
18 that there will continue to be an unmet need for
19 OB, for acute mental illness, and for
20 medical/surgical services in this community.
21 We're hoping this Board will use its
22 discretion and the foresight it was empowered
23 with to improve the access to health care in this
24 community, rather than to limit it, and, with

1 that, we're prepared to answer any questions or
2 address any concerns the Board members may have.
3 CHAIRMAN LOPATKA: Questions or
4 comments from the staff or other Board members?
5 Mr. Mark.
6 SECRETARY MARK: Thank you, Madam
7 Chair.
8 I'd like to respond to some of Dr. Kaplan's
9 remarks because I think they're very important.
10 He talked about -- if my notes are correct, he
11 talked about a high growth rate in the area, he
12 talked about the fact that this planning area had
13 a very high -- I think you said maybe the highest
14 in the state -- number of people leaving the area
15 to seek care --
16 DR. KAPLAN: That's correct.
17 SECRETARY MARK: -- versus coming
18 into the area, what we commonly, in our
19 terminology, call outmigration.
20 You talked about the birth rate, the
21 demographics, the change in average length of
22 stay, and I think all -- and the ages or the use
23 rate of hospitals by population.
24 And I think all of these are precisely

1 critical concerns in the assessment of health
2 care needs, and I would suggest that all of these
3 are precisely key elements in the bed-need
4 methodology that this Board has utilized to
5 determine one of its criteria for need, which is
6 a calculated bed need.
7 And that calculated bed need -- for
8 Mr. Penn and Dr. Burden, who are not that
9 familiar with it, that bed need is a fairly
10 sophisticated formula that looks at historical
11 utilization of hospital -- patient hospital days
12 or hospital beds by different population groups.
13 It then projects the population, takes a
14 projected population by those same age groups,
15 and applies that utilization rate to those
16 projected age groups, and I would suggest that,
17 if this is a high-growth area, those projections
18 reflect the fact that it's a high-growth area.
19 For Mr. Penn's information, the source of
20 our data for our projections are the State of
21 Illinois projection numbers.
22 We then, within this formula, also
23 incorporate, as required by State statute, a
24 consideration already for what Dr. Kaplan talked

1 about, people seeking services outside of the
2 area, and, in the case of our existing formulas,
3 the Board uses 50 percent of all those seeking
4 elsewhere, adds that back into the need in the
5 local area in the case of medical/surgical
6 pediatric services. In the case of obstetrical
7 services, the Board utilizes 85 percent pulling
8 back into the area.
9 Now, that's regardless of why people go
10 elsewhere. People may be going elsewhere because
11 of inaccessibility or issues of accessibility.
12 They may be going elsewhere because there's a
13 better provider elsewhere or a preferred doctor
14 elsewhere. We don't make that determination.
15 The point to the Board is that, within the
16 formulas, these essential planning considerations
17 are already incorporated, and that's the
18 important thing for the Board members to know.
19 DR. KAPLAN: Mr. Mark, we agree.
20 SECRETARY MARK: Thank you.
21 DR. KAPLAN: And my reason for
22 bringing this up is to make the case that
23 these -- that the 10-year projection is on track,
24 that the population exceeded our expectations in

1 2005, '6, and '7. Now housing starts have
2 slowed, but we still have birth rates and aging
3 demographics, and we believe that the calculated
4 bed need is -- stands as-is and that the economic
5 turndown is not going to sway us from
6 the inventory.
7 The second thing is just an additional
8 clarification. The projected need for hospitals
9 within the planning area is just that. They
10 project population out 10 years, they come up
11 with a use rate based on the factors that
12 Mr. Mark explained, and that is the use rate
13 within Planning Area A-13 hospitals for patients
14 that currently receive care within that planning
15 area.
16 But as a point of clarification, for
17 outmigration -- the 50 percent number is a static
18 number for accounting for patients in 2005, that
19 50 percent of them would return into the planning
20 area for care, but that 400,000 people, half the
21 population that receive care outside the planning
22 area -- there is no population projection put on
23 that outmigration number. And we have always
24 maintained, in our agreement to disagree, that

1 that would be a significant factor that's not
2 accounted for in the methodology.
3 SECRETARY MARK: It is accounted for.
4 It's not accounted for the way you would like it
5 to be.
6 DR. KAPLAN: It's not projected.
7 CHAIRMAN LOPATKA: Other questions or
8 comments?
9 MEMBER BURDEN: I want to thank
10 Dr. Kaplan for helping me understand the growth
11 in Will County more clearly.
12 I would like to add one comment, which has
13 nothing to do with your application. It's your
14 comment about the railway project.
15 If you can get the people in that affluent
16 community of Barrington and Barrington Hills to
17 agree, then Canadian Railway can possibly bypass
18 the city, and all of us who live in the city can
19 drive around with more freedom. So I hope that
20 comes.
21 I'm sorry. I just had to make a comment
22 about that. Thanks.
23 CHAIRMAN LOPATKA: Other questions or
24 comments?

1 Yes, Mr. Carvalho, because I have quite a
2 few when I get the opportunity. Go ahead.
3 MR. CARVALHO: Okay.
4 Most of the comments have been made in the
5 past, and so I don't want to rehash responses to
6 many of those comments that you've made in the
7 past and made again today.
8 But I think one thing -- and I alluded to
9 it in the application from Lindenhurst, as well.
10 The charge of this Board by statute and by rule
11 is not to do a sort of subjective, gestalt,
12 everyman identification of need. That would be
13 incredibly subjective and incredibly open to
14 abuse, and so the legislature has identified
15 criteria for evaluation of need, and then the
16 Board has adopted rules through the process that
17 involves public comment.
18 Everyone, including you, were . . . had an
19 opportunity to participate in that rule-making
20 process. And our rules are published, and then
21 they're approved by the Joint Committee on
22 Administrative Rules, which is a committee of the
23 legislature, and then they become the measures by
24 which applications are judged.

1 And what we have seen, especially in the
2 case of new hospital applications for the last
3 five years, is that, under the rules that have
4 existed in every iteration over the last
5 five years -- because they have changed -- and
6 under the statute that -- under every iteration
7 over the last five years because the statute has
8 changed, that none of the new hospitals have met
9 the statutory and regulatory definition of need.
10 There's an old expression lawyers sometimes
11 use, that when the facts are against you you
12 argue the law, and when the law is against you
13 you argue the facts, and when they're both
14 against you you pound on the table.
15 And so, in this process of these several
16 hospitals who applied for applications in the
17 face of statutory and regulatory need criteria
18 that say that new hospitals are not necessary, to
19 varying degrees and at varying volume levels and
20 using varying types of shoes, the Applicants have
21 pounded on the table.
22 And they've made arguments, as you heard
23 earlier today, about EMS, and they've made
24 arguments about the bed ratio per population, and

1 they've made arguments about, "Well, we think
2 various aspects of your formula should be done
3 differently."
4 And they've also obscured the fact -- I
5 think often to everyone in the process a
6 disservice -- that these bed-need calculations
7 are not talking about the need for beds tomorrow.
8 They are talking far out in the future and
9 allowing for the fact that it takes time to build
10 something. And so, understandably, we look far
11 out into the future, but, nonetheless, the
12 projections are based in the future.
13 And so, for example, if -- let's take it
14 out of the hospital arena so as not to be
15 pointed. If -- earlier today we heard an
16 analysis of a nursing home request --
17 DR. KAPLAN: Mr. Carvalho, may I
18 ask -- if you're going to say that people take
19 facts out of context or whatever -- the point
20 you're trying to make -- can you use actual
21 examples regarding our project?
22 Because I believe we tried very hard to
23 keep the data clear. Any data that we've ever
24 presented -- like bed-to-population ratio in

1 other cases -- is just to further support what
2 we're saying, so I prefer you stick to examples
3 that we can address.
4 CHAIRMAN LOPATKA: Well, the bed-to-
5 population ratio is a very good one because you
6 and another Applicant have used it in a way that
7 it was never intended to be used, and I would
8 like -- I am not as eloquent, but I'd like
9 Mr. Mark to reiterate what he said for the
10 earlier Applicant to get it on this record,
11 as well, because it's a red herring to use that
12 in the way --
13 DR. KAPLAN: We --
14 CHAIRMAN LOPATKA: -- that the
15 Applicants for new hospitals have tended to
16 use it.
17 DR. KAPLAN: Right. We -- we --
18 CHAIRMAN LOPATKA: Okay. You wanted
19 an example, and that's the one I'm citing.
20 Would you give your explanation again that
21 you gave earlier this afternoon.
22 SECRETARY MARK: I wish I had the
23 rule in front of me.
24 Mike, do you have that handy by any chance?

1 The bed-to-population ratio is used within
2 the Board's rules and has been for 30 years in
3 only one context, and that is as a demonstration,
4 if you exceed it, of showing a maldistribution.
5 It's the only context of bed-to-population ratio
6 that's used.
7 I would suggest within our rules -- and I
8 would suggest this conceptually, as well as in --
9 pertaining to your project -- that a much more
10 accurate and a much more refined index of
11 calculated bed need is in the bed-need
12 methodology because that is differentiated and
13 stratified by age and use rate and projections,
14 also by age, which is a much more compelling
15 statistical argument than overall age to --
16 overall beds to overall population.
17 DR. KAPLAN: Sure. And we clearly
18 understand how this is used in the rules. We
19 know that it's used to show overbedding, but we
20 didn't use that ratio to say, "See, we need a
21 hospital." We used that ratio as one of many
22 things we looked at that keep coming back to the
23 same fact, there's a bed need in the area.
24 It's projected, there's high

1 outmigration -- we went through multiple tests of
2 needs. I purposely didn't bring up the bed-to-
3 population ratio because it's confusing, but it
4 was only just one more multiple test of need.
5 SECRETARY MARK: And if I may, in
6 response to Mr. Silberman's comments, the
7 hundred-bed minimum size for a med/surg unit has
8 been in the rules for many, many years; you're
9 correct. The Board has reaffirmed that number,
10 by the way, in its new rules that will be in
11 effect on February 5th.
12 MR. SILBERMAN: That does, though,
13 make it a mandatory requirement for an
14 application.
15 SECRETARY MARK: None of the rules
16 are mandatory. You can say that of any rule on
17 the book.
18 DR. KAPLAN: We agree.
19 SECRETARY MARK: But the Board has
20 looked at that particular rule and examined it
21 and has reaffirmed it.
22 DR. KAPLAN: But we agree with you
23 that that rule is not an absolute for the
24 approval of a hospital.

1 SECRETARY MARK: No rule, as far as I
2 know, is absolute.
3 Except maybe paying the application fee.
4 (Laughter.)
5 CHAIRMAN LOPATKA: I -- just to give
6 a couple of other examples.
7 Just like the prior Applicant, you have
8 focused your application almost entirely on
9 either your planning area or facilities within
10 30 minutes, and, again, I spent a lot of time
11 with Table 1, which is on -- this one is not
12 numbered, but it's the third or fourth page in.
13 The reality is that your proposed hospital
14 is -- it's within 45 minutes of four planning
15 areas. Okay? Which never gets mentioned, and
16 it -- and I want to make the point I made with
17 the earlier Applicant before us.
18 You focused on potential maldistribution,
19 which is, you know, one of the sections of the
20 rules, and you've totally ignored the 45 minutes,
21 which, in the rules, is the basis for
22 establishment of additional hospitals, allocation
23 of additional beds, variances to bed need,
24 et cetera.

1 And so I just wanted to again, even though
2 there is -- and I'll take med/surg to start with
3 because med/surg -- if you don't have a med/surg
4 base, you don't have a need for an acute care
5 hospital.
6 I went through -- and these are the 2007
7 bed numbers -- and I found, just for med/surg,
8 that there were a total of 5 -- if you go
9 through all 45 -- if you go through a total of
10 564 med/surg beds that were available as an
11 average beyond occupancy -- and, as I stated with
12 the earlier Applicant, this is not total number
13 of beds that you're licensed for. These are
14 total number of beds to bring you to your
15 occupancy levels, which are based on the number
16 of beds that you have. That's a huge, huge
17 number.
18 Within 30 minutes -- and I didn't even
19 include Adventist Bolingbrook -- I found 71 beds
20 that were currently available at any given time
21 in 2007 data.
22 You also wanted to mention --
23 DR. KAPLAN: Is that all categories
24 of service?

1 CHAIRMAN LOPATKA: No. This is
2 med/surg. I'm speaking strictly about med/surg.
3 So, again, you know, you focused almost
4 your entire application on one section of the
5 statutes and you ignored numerous others, and
6 that is a grave concern to me.
7 I also wanted to mention that Adventist
8 Bolingbrook was before us at our last Board
9 meeting in November. They were -- they were here
10 on a rather routine issue, but they volunteered
11 information about their 10 months of service, and
12 they were, total for the hospital -- this was
13 sworn testimony -- at 26 percent occupancy.
14 And I want to say, you know, when the
15 original four hospitals came before us -- which
16 was one of the very first things that came before
17 this Board in -- I believe it was October of
18 '04 -- I was the dissenting vote on Bolingbrook.
19 It passed with three votes, one against, and
20 one abstention, and so I have been very
21 consistent in how I have tended to look at --
22 look at the rules.
23 But I was struck to hear that the census
24 was that low because I've heard numerous times --

1 and I think I've heard it from Edward -- that
2 Bolingbrook would be full and bursting at the
3 seams within a year of when it opened. And so I
4 wasn't convinced there was a need at that time,
5 and I -- I'm not sure that it's not being borne
6 out to some extent.
7 As was said earlier -- and I'm going to use
8 this in a different sense -- length of stays are
9 lessening. I think that one of the reasons
10 that -- at least my perceived -- need for not
11 having new beds is increasing is that length of
12 stay is very definitely shortening and more and
13 more care is being provided on an outpatient
14 basis.
15 And I really don't see, given this kind of
16 current availability of beds just in the med/surg
17 category, a need for a new hospital in -- in your
18 area at this time, so --
19 DR. KAPLAN: This is such an
20 important point. May I address the 45-minute --
21 CHAIRMAN LOPATKA: Well, it is. And,
22 you know, the 45 minutes drives a number of
23 these, but these were actually third rails. I
24 mean, both you and the other Applicant have

1 stayed away from any of these, nor have you
2 really addressed them -- you know, the negatives
3 that you've been consistently getting -- and
4 you've been focusing on -- in one specific part
5 of the statute --
6 DR. KAPLAN: The --
7 CHAIRMAN LOPATKA: -- or the rules, I
8 should say.
9 DR. KAPLAN: So let's just start --
10 you touched on a number of issues. One is the
11 Bolingbrook Hospital census, and I did address
12 that. We know it's greatly attributable to the
13 restrictive policies. They do not even --
14 CHAIRMAN LOPATKA: Well, I'm not sure
15 that you can make that statement, sir. I
16 think --
17 DR. KAPLAN: We have 900 doctors on
18 our staff. We are 7 miles away. Only 30 of them
19 are on the Bolingbrook Hospital staff. I have
20 very close personal knowledge of why they are not
21 on staff, and it's in regards to this restrictive
22 policy.
23 Now, in regards to the 45-minute radius,
24 one of the things I did address directly in

1 the opening statement is that, if you look at
2 ICU beds within 45 minutes of the people who
3 have utilization data available, which is
4 12 hospitals, there are only two beds
5 available -- or -- three? Two?
6 MS. KENNEY: Two -- well --
7 DR. KAPLAN: Somewhere about three
8 occupancy. But I want you --
9 CHAIRMAN LOPATKA: I got 10. I got
10 10 based on the data on this table for 2007 --
11 DR. KAPLAN: Okay. But there --
12 there --
13 CHAIRMAN LOPATKA: -- which is the
14 most -- it's a year out of date, but it's the
15 most recent data that we have.
16 DR. KAPLAN: Right. There are
17 several points I want to make on this. One is
18 that these are 2007 statistics. This hospital
19 would open in late 2013. That's why we're
20 planning ahead.
21 The second point I'd like to make is
22 that -- is that I acknowledge and understand that
23 the rules are written this way. And -- I married
24 into a farming family and, out on the farm, I

1 understand this rule. It makes sense. You're
2 not going to have a hospital in every small town
3 in rural Illinois. You just can't support them.
4 However, in a metropolitan area, this is
5 extremely impractical to take a large population
6 in a concentrated area and rely on a myriad of
7 hospitals distributed within a 45-minute
8 radius -- they might not have the right
9 insurance, they can't go to their own doctors,
10 there might not be medical records, there's poor
11 continuity of care, there's quality, there's
12 safety issues -- to put it in context -- to just
13 visualize this, if one were to have a condominium
14 in the Water Tower Place and they needed a
15 hospital and there was a hospital available in
16 Downers Grove at Good Samaritan Hospital -- there
17 was a bed available there -- we should not create
18 more beds closer to the person's home because
19 they could drive out of the city, out to Good
20 Samaritan Hospital in Downers Grove.
21 And I think that anyone knows in a large
22 metropolitan area it's just not practical. I
23 understand the rules. It's just not safe, it's
24 not practical, and I think it's more practical to

1 look within 30 minutes because that's a number
2 that people can be with their doctors. They can
3 be with their own medical records.
4 So I do think -- I understand it's a rule,
5 but I think we have to look at it in the context
6 of reality.
7 CHAIRMAN LOPATKA: Well, to say -- I
8 mentioned to you earlier, not counting Adventist
9 at all, at the end of '07 there were 72 beds --
10 med/surg beds -- available within 30 minutes of
11 your proposed site, which is almost the number
12 that you're requesting.
13 DR. KAPLAN: Does that include all
14 the new State agency numbers? Copley had 26 out
15 of service. I am not sure about St. Joe's
16 numbers.
17 CHAIRMAN LOPATKA: I --
18 SECRETARY MARK: There were zero out
19 of service at St. Joe's.
20 MS. KENNEY: We know that for the
21 hospitals within 30 minutes. I'm not sure we
22 know that about all the hospitals within 45.
23 CHAIRMAN LOPATKA: Well, I mean,
24 anyone else could have sat and done the

1 calculations that I did over an extensive period
2 of time. And while I'm at it, let me just
3 finish.
4 For AMI beds -- actually, there is a
5 projected need of 24 by 2015. Currently within,
6 again, the 45 minutes of the proposed hospital,
7 there are 117 that are available based on the
8 census.
9 Now, you can go and do these figures
10 yourself. Even OB, which is the biggest need of
11 all, I found currently there are 23 OB beds
12 available, at least as of the end of '07.
13 And, by the way, I specifically asked about
14 OB at Adventist Bolingbrook, since I have an
15 interest in that, and their OB census pretty much
16 mirrors the overall census at this point.
17 So, again -- and I'm not even counting that
18 because, you know, we don't have official
19 figures, but we have sworn testimony on it. And
20 I found 10 ICU beds -- again, you know, based on
21 the census.
22 And this is taking, you know, whatever the
23 State standard is for ICU beds, 60 percent. For
24 med/surg and OB, it varies with the number of

1 beds that you have and not total beds but
2 bringing it up actually to what would be the
3 standard, and -- and that's a huge number of
4 beds.
5 The other thing I wanted to note is that,
6 even though it's preliminary data, I'm finding --
7 for med/surg these preliminary sheets on what
8 hospital beds actually exist -- a change of
9 one bed for med/surg based on the preliminary
10 data which you appended to the end of your
11 application, if I have read that correctly.
12 SECRETARY MARK: I believe so.
13 And, again, for the record, I'd like to
14 point out that we have included -- at the request
15 of the Chair, we have included the preliminary
16 results of the annual bed report appended to this
17 SAR, and I believe the Applicant has a copy of
18 the entirety of that.
19 MS. KENNEY: Yes, but I don't -- I
20 don't believe that that includes all of the
21 hospitals within 45 minutes.
22 SECRETARY MARK: The entirety of the
23 report does.
24 MS. KENNEY: Oh, okay. I don't know

1 that we've had access to that.
2 SECRETARY MARK: This report
3 includes -- as staff suggested, we included the
4 other facilities within the planning area --
5 DR. KAPLAN: I do want to mention --
6 SECRETARY MARK: -- for illustrative
7 purposes only.
8 DR. KAPLAN: -- mention one thing
9 about OB at Adventist Bolingbrook Hospital.
10 They have not recruited a full staff of
11 obstetricians yet. Once you do, it takes a while
12 to ramp up. As you know, it takes nine months to
13 have a baby.
14 CHAIRMAN LOPATKA: Yep.
15 DR. KAPLAN: And they've -- they've
16 moved from 29 deliveries a month, progressively
17 increasing every single month to in October they
18 had 81, but they are on a completely steady
19 incline.
20 The second point I want to make is that
21 we're placing a lot of weight on 2007 data and a
22 lot of weight on hospitals that are a significant
23 distance -- I understand within the rules but --
24 a significant distance from this planning area.

1 CHAIRMAN LOPATKA: Well, this is data
2 that's one year back.
3 DR. KAPLAN: But we're looking at a
4 hospital that will be opening in late 2013, so
5 we're thinking six years ahead but making a
6 decision on data that's a year old, and that's
7 why there's IDPH calculations and projections.
8 The --
9 CHAIRMAN LOPATKA: Well, could I make
10 one more point and then I will not say anything
11 for a while.
12 Another point I wanted to make -- and I
13 made it earlier -- at least half of the bed need
14 for med/surg in your planning area is actually
15 pediatric beds, which have been discontinued.
16 Now, the reality is that pediatrics has
17 probably changed more than any other service in
18 terms of how it's delivered. In most hospitals,
19 you know, children who have major problems go to
20 pediatric specialty hospitals. No adult was ever
21 in a pediatric bed, yet historically the med/surg
22 and pediatric beds have been counted as though
23 they're one, so we had a doubling of the need for
24 med/surg beds based on Silver Cross eliminating

1 pediatric beds.
2 And I wanted to make that point, as well.
3 It's something that's always bothered me, and I
4 questioned why that is because the beds are not
5 synonymous.
6 DR. KAPLAN: I would agree that
7 pediatric admissions are diminishing and it's
8 becoming more of an outpatient business --
9 CHAIRMAN LOPATKA: But they're being
10 counted as --
11 DR. KAPLAN: -- but the IDPH --
12 THE COURT REPORTER: Wait, wait,
13 wait. Excuse me.
14 (There followed a discussion
15 outside the record.)
16 DR. KAPLAN: You're in charge. Go
17 ahead.
18 CHAIRMAN LOPATKA: Okay. No, I'm
19 just saying -- but they're being counted as
20 med -- as med/surg needs.
21 DR. KAPLAN: Right. In the IDPH
22 calculations that's accounted for --
23 CHAIRMAN LOPATKA: Yeah.
24 DR. KAPLAN: -- because they look at

1 total need by age group and they look at total
2 utilization today -- well, in 2005 -- so that's
3 already accounted for in the calculations.
4 SECRETARY MARK: That's correct.
5 CHAIRMAN LOPATKA: Okay. I'm sorry.
6 Mr. Carvalho, I apologize because I cut you
7 off in midthought before, but . . .
8 MR. CARVALHO: That's okay. Let
9 me -- let me -- the upside of that is I'll
10 probably finish my thought quicker, so . . .
11 everybody will like that. Let me complete the
12 thought and then add one other thought and then
13 I'm done.
14 The thought I was completing was that all
15 of the new hospital applications that this Board
16 has seen over the last five years have failed to
17 meet the need requirement as laid out in the
18 rules and the statutes. And on account of that,
19 I, in my role as ex officio member of this Board,
20 have spoken to that point in each and every one
21 of those applications.
22 I do not vote. And so, although
23 Mr. Silberman pointed out that, notwithstanding
24 what I had pointed out, one of those hospitals

1 was approved, I pointed out the deficiencies in
2 that application just as consistently and just as
3 emphatically as I did all the others.
4 That's my role here on this Board, and it's
5 my role to point it out in the case of your
6 application because your application has also
7 failed to meet the criteria in the Board -- laid
8 out by the Board.
9 Now, perhaps I've pointed it out more
10 frequently in the case of your application
11 because your application has been before the
12 Board more frequently than any of the other
13 applications and so it comes up more often, but
14 you aren't being singled out for that purpose.
15 Secondly, one of the rules -- and this is a
16 rule -- we were talking earlier about the rules
17 that are always in play and the rules that aren't
18 always in play.
19 One of the rules that is always in play and
20 that I take extraordinarily seriously is the
21 ex parte rule. And your counsel probably knows
22 the ex parte rule, as anyone in the room, since
23 he served as counsel to this Board.
24 The ex parte rule certainly, as I've

1 interpreted it and as I take it very seriously,
2 prohibits me from responding to matters
3 concerning this application outside of this Board
4 room. That's generally a good thing; however, it
5 also puts me and others involved in this process
6 at a serious disadvantage when material outside
7 of this Board room is brought to the public in a
8 way that I'm sure your counsel understood makes
9 it impossible for us to respond. The only place
10 we can respond is in this room. And if -- with
11 the indulgence of the Chair, I'll take a few
12 moments to do so.
13 And in particular, so as not to be opaque
14 to the members of the Board who may not have seen
15 it, I will only quote what is quoted in the
16 papers because I know that newspapers do not
17 always characterize things correctly.
18 MR. SILBERMAN: May I be heard on
19 this, please.
20 CHAIRMAN LOPATKA: David, I feel a
21 need, also, to say something, but I didn't want
22 it to be part of the application process, and I
23 probably need some legal advice.
24 I have some very serious concerns about

1 things that have been in the public domain, but I
2 didn't want to mix it in with -- with the hearing
3 of this application, and I was going to wait
4 until after the vote was taken to make the
5 comments.
6 Would you feel comfortable waiting, or do
7 you feel that -- is it appropriate, actually --
8 MR. CARVALHO: If counsel --
9 CHAIRMAN LOPATKA: -- to make these
10 comments at this time? And I defer to our
11 counsel.
12 MR. CARVALHO: If counsel
13 indicated -- as I indicated, because the ex parte
14 rules prohibit us from making any comment about a
15 pending application outside of the Board, I
16 want -- I thought this was the only opportunity
17 to do so. If counsel indicates that, after the
18 application is considered, comment -- the Board
19 still being in session -- comments can be made --
20 CHAIRMAN LOPATKA: Well, I would like
21 a clarification on that, too.
22 MR. SILBERMAN: And may I ask to be
23 heard on this since reference to my understanding
24 and knowledge of these rules has been made? And

1 I think it is fund -- the -- reference is being
2 made to comments that were not made to any Board
3 member.
4 Reference is being made to comments that
5 are not part of this application process, that
6 were not submitted in any way, shape, or form
7 with regards to this application, and I believe
8 even the bringing up of this subject is
9 fundamentally improper. It is not reflected in
10 the rules.
11 The ex parte communication -- there was no
12 communication with any Board member. There was
13 no materials or information sent to any Board
14 member, and the bringing up of this information
15 now does nothing but to taint the consideration
16 of this application.
17 CHAIRMAN LOPATKA: Well, I --
18 Mr. Silberman, you're no longer our counsel. I
19 asked our counsel to respond to this. That is
20 whom the Board needs to listen to.
21 MR. URSO: Taking everything into
22 consideration and this being an open meeting, I
23 think it's proper for any Board member or any
24 officio member -- ex officio member -- to have an

1 opportunity to speak what they want to speak
2 about in regards to this application, but I think
3 it might be prudent on the Board's part and
4 ex officio members to do that after a vote is
5 conducted and let's deal with the subject matter
6 of this application.
7 CHAIRMAN LOPATKA: That's kind of
8 where I'm coming from, and I'm glad to hear that.
9 But -- because I don't want the record of
10 this application -- I won't -- I don't want to
11 use the word "tainted," but I don't want it
12 affected in any possible way.
13 I want us to look at the merits initially
14 through the vote -- look at the merits of this
15 application, period, and then I have a few words
16 to say later, too.
17 But, anyway . . . so --
18 MR. URSO: Why don't you proceed with
19 consideration of this application.
20 CHAIRMAN LOPATKA: Okay. Are there
21 any -- you know, are there any other questions or
22 comments from any other Board members
23 particularly regarding this particular
24 application?

1 (No response.)
2 CHAIRMAN LOPATKA: Everyone feels
3 that anything that needs to be said has been said
4 and put on the record --
5 MEMBER AVERY: Yeah.
6 CHAIRMAN LOPATKA: -- prior to --
7 okay.
8 Well, hearing that, I will entertain a
9 motion for approval of Edward Plainfield
10 Hospital, Plainfield, to establish a new 130-bed
11 acute care hospital in Plainfield.
12 MEMBER BURDEN: So moved.
13 MEMBER AVERY: Second.
14 SECRETARY MARK: The motion was made
15 by Dr. Burden, seconded by Ms. Avery.
16 Ms. Lopatka.
17 CHAIRMAN LOPATKA: I am going to be
18 consistent and continue to vote no. I -- as I've
19 said and I will repeat for the record, the
20 Applicant has focused almost exclusively on one
21 or two small sections of the regulations
22 regarding this application and has totally
23 ignored those that deal particularly with
24 establishing new hospitals, allocation of

1 additional beds, variances to bed need, also
2 location alternatives and need for the project,
3 which were all negatives, and that is a very
4 important consideration for me.
5 I did want to note that there is -- there
6 is a substantial need for OB beds projected
7 particularly, but I don't believe that the need
8 for a new hospital has been established in any of
9 the documentation that has been submitted.
10 SECRETARY MARK: Ms. Avery.
11 MEMBER AVERY: I'm going to vote no
12 because --
13 THE COURT REPORTER: Please use your
14 microphone. Excuse me.
15 MEMBER AVERY: No, because of the
16 same reasons that were stated. The application
17 just did not demonstrate a need for a new
18 hospital in that area, and there are numerous
19 facilities that are operating before the State --
20 below the State utilization targets.
21 SECRETARY MARK: Dr. Burden.
22 MEMBER BURDEN: This has been a very
23 lengthy, protracted discussion here, and I will
24 probably -- I will vote for the project. I will

1 vote yes but I will recognize that there is a
2 great deal of discussion here that -- some of
3 which is somewhat concerning to me.
4 But I am impressed with Plainfield and
5 their attempts to have an opportunity to build a
6 facility in this community. It has addressed, I
7 thought, very well the concerns, having been
8 before this Board since I've been a member of it
9 four times, I believe -- not that that means it
10 should be approved today.
11 But I would vote yes based on what I have
12 ascertained.
13 SECRETARY MARK: And Mr. Penn.
14 MEMBER PENN: I find it easy to vote
15 yes to this application. I appreciate your
16 concerns for the mental health care, the travel,
17 patients seeking their own physicians, physicians
18 of their choice.
19 And I'm on record as voting yes for your
20 hospital.
21 DR. KAPLAN: Thank you.
22 SECRETARY MARK: This application --
23 the motion was not passed. The Applicants have
24 received a denial. You will be afforded an

1 opportunity for administrative review.
2 MR. URSO: Administrative hearing.
3 SECRETARY MARK: Hearing. I am
4 sorry. Administrative hearing.
5 CHAIRMAN LOPATKA: I would appreciate
6 the Applicants staying there for just a few
7 minutes because I have a few things to say as the
8 Acting Board Chair.
9 I pride myself on being a professional. I
10 think everyone that I have dealt with on this
11 Board since I was appointed has been very
12 professional, my former Board members and
13 particularly the staff who I have been very
14 blessed to work with, and at one time that
15 included your counsel, who is sitting facing me
16 directly.
17 I have been very distressed -- and I'm
18 going to let both Mr. Carvalho and Mr. Mark, if
19 he chooses to say anything, say a few words,
20 too -- about comments that have been made in the
21 press by members -- I'm sorry.
22 MEMBER AVERY: I -- I just -- in your
23 open statements -- are we going to give them a
24 chance to make comments for --

1 CHAIRMAN LOPATKA: No. Actually, I
2 just want them to be messengers to bring this
3 message back, and I want to get this on the
4 public record.
5 There have been, actually, personal attacks
6 in the press and one of them which I read was by
7 your CEO regarding two of our ex officio members.
8 And I want to put on the record that the
9 reason that there are ex officio members from
10 three Departments is not accidental. Each of
11 these gentlemen -- it happened to be gentlemen at
12 the current time -- bring expertise from the
13 Department of Public Health, from the Department
14 of Human Services, from Healthcare and Family
15 Services, which is pertinent to the work of this
16 Board, and I have actually -- actively encouraged
17 them to be active, to speak out. Frequently
18 they're -- they've been in a teaching mode when
19 we have had new Board members because there is a
20 steep learning curve for serving on this Board.
21 And let me tell you, I -- I have been on
22 4 1/2 years now and Ms. Avery just one month less
23 than I have, and I think this has been very
24 unfair.

1 And I have to say, on Edward's behalf,
2 those of you who have appeared before us have
3 always been very professional, and I have no
4 concern about that, but I feel like there's good
5 cop/bad cop going on here. You come in and
6 you're professional and you're all smiles, and
7 always within a week or two prior to your
8 appearing before us there have been comments made
9 in the press.
10 And let me tell you off -- well, it's not
11 off the record. It's on the record.
12 If there were any way that I could have
13 supported your application, I would have done so
14 because I have lived personally through about
15 four years of hell with this particular
16 application, and I need to get this off my chest.
17 And I have tried to be dispassionate; I've
18 tried to be fair in how I've looked at it. Not
19 everyone else on the Board has viewed some of
20 these applications the way that I have, but I
21 have striven to be consistent, and I've striven
22 to be fair, and -- and, basically, that's what I
23 have to say.
24 But I feel that two excellent people have

1 really been besmirched and have not really had
2 the opportunity to defend themselves, and so this
3 is an open meeting, and, David, since you were
4 the one that initiated this, you go first.
5 I don't know whether Mr. Mark feels
6 comfortable making any comments, but, if he does,
7 I would like to hear from him, too.
8 And all I really want you to do is to take
9 this message back. I'm not holding you at the
10 table accountable in any way for anything that's
11 been said or done.
12 Mr. Carvalho.
13 MR. CARVALHO: I will be very brief.
14 It has been suggested that the reason why
15 the ex officio members speak up in pointing out
16 deficiencies in this application are personal,
17 rather than professional, and, in particular,
18 that we are seeking -- and I quote -- "to exact
19 some sort of revenge because of the courageous
20 actions of the CEO of this hospital with respect
21 to a prior Planning Board that was corrupt."
22 Contrary to the suggestions of your CEO,
23 the staff of the Health Facilities Planning Board
24 and I, in particular, are, in fact, grateful to

1 her for her courageous efforts to expose the
2 corruption of that prior Health Planning Board.
3 Without her efforts the corruption would
4 undoubtedly have lasted longer and the reforms
5 that were ushered in with this new Planning
6 Board, a very different set of people, operating
7 in a very different fashion, would have been
8 delayed.
9 I have not sought the permission of the
10 U.S. Attorney's office, as your CEO did, to speak
11 about these matters, and so I won't go into any
12 details, but if you look at the public record, as
13 presented in the transcripts of the trial of
14 Mr. Rezko, you will see that, if your CEO had not
15 taken the action she did, they were days away
16 from trying to get rid of me because of the
17 impediments that I was putting -- and
18 specifically referred to me as a pain in the
19 butt. I took that . . . well.
20 And so I'd like to thank Ms. Davis for what
21 she did. I harbor absolutely no ill will towards
22 her. I have been consistent in presenting on the
23 merits what I see are deficiencies and against
24 our rules on every new hospital application, and

1 I have treated your hospital application no
2 differently.
3 SECRETARY MARK: If I may, Madam
4 Chair, just a few comments because I was also
5 named by name by Ms. Davis and -- or at least she
6 was quoted as stating my name.
7 And I concur a hundred percent with what
8 Mr. Carvalho just said. I also -- I also give
9 her a lot of credit and understand her
10 frustration with that Board, and she had every
11 right in the world to be so frustrated, given the
12 facts that were borne out.
13 What I do take issue with is that she made
14 a statement that my behavior and implied behavior
15 of our staff is less than professional today. I
16 would like to say very explicitly -- I have
17 30-some years' experience as a health care
18 planner, as a health care architect. This is my
19 livelihood; this is my profession, my career.
20 I take great pride in the fact of being a
21 professional. We have taken great effort and, I
22 believe, made lots of progress in the last
23 five years, myself and staff, of treating
24 everybody fairly, everybody professionally. And

1 if anybody at any time perceives that I or my
2 staff or other staff of the Board are doing
3 anything less than that, I would very much ask
4 them and very much encourage them to bring that
5 to the attention of our attorney, of our Chair;
6 if those people aren't satisfactory, to the
7 Inspector General of this State.
8 DR. KAPLAN: May I make one comment?
9 CHAIRMAN LOPATKA: Yes.
10 DR. KAPLAN: I am very disappointed
11 with this conversation. We came here to improve
12 access for care for Plainfield residents in the
13 area that we care very much about and we have
14 been very focused on.
15 It's very difficult, after hearing this
16 conversation, to believe that this application
17 was judged upon without bias. And --
18 CHAIRMAN LOPATKA: Well, sir, I take
19 that as a personal insult, and I want to put on
20 the record that never, ever have staff in any way
21 suggested how I -- and I can ask the other Board
22 members to affirm on their own -- how I should
23 vote on anything.
24 And anyone who knows me knows that I'm my

1 own person, so I brought no bias to my looking at
2 this application, and I have been very consistent
3 with the hospital each time that you have come
4 before us.
5 So I just want to put that on the record.
6 MR. SILBERMAN: And I don't believe
7 Mr. -- Dr. Kaplan intended to intimate that, but
8 I do believe the concern he was trying to
9 express -- and he will correct me if I'm wrong --
10 is, as I previously noted, this is information
11 that wasn't part of this application. This
12 was -- this is --
13 CHAIRMAN LOPATKA: And this is why
14 this is being said publicly, in a public meeting,
15 after the application was heard.
16 MEMBER AVERY: This conversation is
17 why -- this should end right now.
18 THE COURT REPORTER: I can't
19 understand you.
20 MEMBER AVERY: This conversation
21 should end right now. We're never going to see
22 eye to eye on this --
23 MR. BUTLER: I agree.
24 MEMBER AVERY: -- there were no

1 biases. I don't talk to any staff until I get
2 here unless I have a question about something on
3 the CD run or the SAR. That is totally, totally
4 allowed for us to do.
5 So I don't think this conversation should
6 be entertained. There are things that's been
7 said about us as a Board that we are not ever
8 going to be able to clarify or people are going
9 to see eye to eye with us.
10 And that statement that was just made was
11 totally, totally out of line. That's why I was
12 against the conversation should take place
13 anyway, although I agree it should be put on the
14 record that these two people have not in any way
15 influenced us on the vote of this application or
16 any other.
17 And I think we should end this discussion,
18 and --
19 CHAIRMAN LOPATKA: Well, I think that
20 the reality is we've been told -- it is now
21 five o'clock, and we have been told that we have
22 to vacate the room at five o'clock. We have --
23 originally, I understood yesterday we could stay
24 later, but that is not the case.

1 And, anyway, I thank you.
2 MR. SILBERMAN: Thank you, Madam
3 Chair.
4 CHAIRMAN LOPATKA: We are going to
5 recess -- oh, I'm sorry.
6 We're going to recess -- for those of you
7 who did not hear it earlier, we are going to
8 recess until 9:00 a.m. tomorrow morning, when we
9 will have executive session, and we plan to be
10 in -- back in public session by 10:30 a.m.
11 tomorrow.
12 (Whereupon, at 4:58 p.m., the
13 hearing was continued to
14 Thursday, January 29, 2009, at
15 9:00 a.m.)
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