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Transcript of **Full Meeting**

Date: February 16, 2016

Case: State of Illinois Health Facilities and Services Review Board

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ILLINOIS DEPARTMENT OF PUBLIC HEALTH
HEALTH FACILITIES AND SERVICES REVIEW BOARD

OPEN SESSION - MEETING

Bolingbrook, Illinois 60174

Tuesday, February 16, 2016

10:01 a.m.

BOARD MEMBERS PRESENT:

- KATHY OLSON, Chairperson
- JOHN HAYES, Vice Chairman
- SENATOR BRAD BURZYNSKI
- SENATOR DEANNA DEMUZIO
- JUSTICE ALAN GREIMAN
- JOEL K. JOHNSON
- JOHN MCGLASSON
- RICHARD SEWELL

Job No.: 93889A

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Reported by: Paula M. Quetsch, CSR

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EX OFFICIO MEMBERS PRESENT:

BILL DART, IDPH

ARVIND K. GOYAL, IHFS

ALSO PRESENT:

JUAN MORADO, JR., General Counsel

JEANNIE MITCHELL, Assistant General Counsel

COURTNEY AVERY, Administrator

NELSON AGBODO, Health Systems Data Manager

MICHAEL CONSTANTINO, IDPH Staff

GEORGE ROATE, IDPH Staff

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P R O C E E D I N G S

CHAIRWOMAN OLSON: The meeting will come to
order, please.

Thank you.

May I have a roll call, please?

MR. ROATE: Thank you, Madam Chair.

Mr. Sewell.

MEMBER SEWELL: Here.

MR. ROATE: Mr. McGlasson.

MEMBER MCGLASSON: Yes, sir.

MR. ROATE: Mr. Johnson.

MEMBER JOHNSON: Here.

MR. ROATE: Justice Greiman.

MEMBER GREIMAN: Here.

MR. ROATE: Dale Galassie is absent.

Senator Demuzio.

MEMBER DEMUZIO: Here.

MR. ROATE: Senator Burzynski.

MEMBER BURZYNSKI: Here.

MR. ROATE: Mr. Hayes.

VICE CHAIRMAN HAYES: Here.

MR. ROATE: Chairwoman Olson.

CHAIRWOMAN OLSON: Here.

MR. ROATE: Eight members in attendance.

1 CHAIRWOMAN OLSON: Thank you. And welcome
2 to our newest member, John McGlasson from Pontiac,
3 Illinois. We're very glad to have you aboard.
4 Welcome.

5 Okay. Next order of business is approval of
6 the agenda.

7 I would like to make a request to hear
8 Project H-09 Rush University Medical Center Master
9 Design after H-02.

10 May I have a motion to approve that change
11 to the agenda?

12 MEMBER DEMUZIO: So moved.

13 VICE CHAIRMAN HAYES: Second.

14 CHAIRWOMAN OLSON: All those in favor say aye.

15 (Ayes heard.)

16 CHAIRWOMAN OLSON: Opposed, like sign.

17 (No response.)

18 CHAIRWOMAN OLSON: The motion carries and
19 the agenda is amended.

20 May I have a motion to approve the
21 transcript from the November 27th, 2015, meeting?

22 MEMBER BURZYNSKI: So moved.

23 VICE CHAIRMAN HAYES: Second.

24 CHAIRWOMAN OLSON: All those in favor say aye.

1 (Ayes heard.)

2 CHAIRWOMAN OLSON: Opposed, like sign.

3 (No response.)

4 CHAIRWOMAN OLSON: The motion passes.

5 The next order of business is executive
6 session. May I have a motion to go into closed
7 session pursuant Sections 2(c)(1), 2(c)(5), 2(c)(11),
8 and 2(c)(21) of the Open Meetings Act?

9 VICE CHAIRMAN HAYES: So moved.

10 MEMBER SEWELL: Second.

11 CHAIRWOMAN OLSON: All those in favor say aye.

12 (Ayes heard.)

13 CHAIRWOMAN OLSON: We are now in executive
14 session that will last about 20 minutes. Thank you.

15 (At 10:02 a.m. the Board adjourned into
16 executive session. Open session proceedings
17 resumed at 10:52 a.m. as follows:)

18 CHAIRWOMAN OLSON: The next order of business
19 is compliance issues, settlement arrangements, and
20 final orders.

21 Juan.

22 MR. MORADO: Madam Chair, I'm seeking a final
23 order in the matter of Advocate BroMenn Medical
24 Center, HFSRB 15-09, Project No. 14-027.

1 CHAIRWOMAN OLSON: May I have a motion to
2 approve the final order?

3 MEMBER BURZYNSKI: So moved.

4 CHAIRWOMAN OLSON: Do I have a second?

5 MEMBER SEWELL: Second.

6 CHAIRWOMAN OLSON: All those in favor say aye.

7 (Ayes heard.)

8 CHAIRWOMAN OLSON: Opposed, like sign.

9 (No response.)

10 CHAIRWOMAN OLSON: The motion passes.

11 MR. MORADO: I'm also seeking a final order
12 on Community Health and Emergency Services,
13 Incorporated, vs. HFSRB, Project No. 14-22.

14 CHAIRWOMAN OLSON: May I have a motion?

15 VICE CHAIRMAN HAYES: So moved.

16 CHAIRWOMAN OLSON: Is there a second?

17 MEMBER SEWELL: Second.

18 CHAIRWOMAN OLSON: All these in favor say aye.

19 (Ayes heard.)

20 CHAIRWOMAN OLSON: Opposed, like sign.

21 (No response.)

22 CHAIRWOMAN OLSON: The motion passes.

23 MR. MORADO: Seeking a final order in the
24 matter of Aurora Chicago Lakeshore Hospital v. HFSRB,

1 Case No. 15-07.

2 CHAIRWOMAN OLSON: May I have a motion?

3 MEMBER DEMUZIO: Motion.

4 CHAIRWOMAN OLSON: And a second.

5 VICE CHAIRMAN HAYES: Second.

6 CHAIRWOMAN OLSON: All those in favor say aye.

7 (Ayes heard.)

8 CHAIRWOMAN OLSON: Opposed, like sign.

9 (No response.)

10 CHAIRWOMAN OLSON: The motion passes.

11 MR. MORADO: We're seeking a final order in
12 Resthave Home of Morrison vs. HFSRB, Case No. 15-08
13 and this is Project 12-022.

14 CHAIRWOMAN OLSON: May I have a motion?

15 MEMBER DEMUZIO: Motion.

16 CHAIRWOMAN OLSON: And a second.

17 VICE CHAIRMAN HAYES: Second.

18 CHAIRWOMAN OLSON: All those in favor say aye.

19 (Ayes heard.)

20 CHAIRWOMAN OLSON: Opposed, like sign.

21 (No response.)

22 CHAIRWOMAN OLSON: The motion passes.

23 MR. MORADO: And, finally, a final order in
24 the matter of Generations Healthcare Network at

1 Oakton Pavilion, LLC, vs. HFSRB, Case No. 15-03.

2 CHAIRWOMAN OLSON: May I have a motion?

3 MEMBER SEWELL: Motion.

4 CHAIRWOMAN OLSON: And a second, please.

5 MEMBER DEMUZIO: Second.

6 CHAIRWOMAN OLSON: All those in favor say aye.

7 (Ayes heard.)

8 CHAIRWOMAN OLSON: Opposed, like sign.

9 (No response.)

10 CHAIRWOMAN OLSON: The motion passes.

11 MR. MORADO: And, Madam Chair, we're seeking
12 a referral today to legal for further investigation
13 of the Albany Medical Surgical Center.

14 CHAIRWOMAN OLSON: May I have a motion to
15 refer this to legal counsel?

16 MEMBER DEMUZIO: Motion.

17 CHAIRWOMAN OLSON: Is there a second?

18 VICE CHAIRMAN HAYES: Second.

19 CHAIRWOMAN OLSON: All those in favor say aye.

20 (Ayes heard.)

21 CHAIRWOMAN OLSON: Opposed, like sign.

22 (No response.)

23 CHAIRWOMAN OLSON: The motion passes.

24 The next order of business is public

1 participation.

2 Jeannie.

3 MS. MITCHELL: You will be called in groups
4 of five. Please come up when called.

5 The first five are Jean Crocco, Ruth Colby,
6 Nancy Dye, Hadley Streng, and Kumar Nathan. And
7 please remember to spell your name at the beginning
8 before you begin speaking for the reporter -- yes,
9 that table right there -- and you do not have to
10 speak in any particular order. You get two minutes.

11 MS. CROCCO: My name is Jean Crocco,
12 C-r-o-c-c-o.

13 CHAIRWOMAN OLSON: Please go ahead.

14 MS. CROCCO: I represent the Pro-Life Action
15 League, a not-for-profit public interest organization
16 that works to promote life and end abortion.
17 Because abortion has been judicially imposed upon
18 this country, we seek to limit the damage to the
19 women seeking abortion and to protect all lives
20 involved, especially here in our own state of
21 Illinois.

22 At this time we have grave concerns about
23 Apollo ASTC because it's under the control of the
24 Drs. Vinod and Vijay Goyal. The Goyals have had

1 control over at least five PTSDs and currently
2 two ASTCs that are primary abortion clinics.

3 As I have previously informed the Board,
4 there were many irregularities in the application
5 process. Apollo was opened with the expressed
6 expectation that it would serve the lower-income
7 members of the community by providing low-cost
8 colonoscopies and other noncontroversial procedures.
9 That has not happened. Also listed on their
10 procedure list but not mentioned at that Board
11 meeting in 2011 were first- and second-trimester
12 abortions. The Pro-Life Action League would have
13 little concern over the operation of Apollo were
14 they to remove those procedures from their list. As
15 it is, though, OB/GYN procedures are the bulk of
16 their business. Hence, our concern.

17 Also troubling to us is that that Albany
18 ASTC in Chicago is seeking to find new personnel to
19 do its abortion procedures and has entered into a
20 contract with the Goyals for staffing. Currently
21 Albany's phone number is answered by Goyal staff
22 setting appointments at one of the facilities owned
23 by the Goyals.

24 We believe that Apollo was approved after

1 the Goyals engaged in deception, showing contempt
2 for the Board and that its license should be revoked.
3 We also believe that Albany should not be allowed to
4 reopen with the Goyals managing.

5 Thank you.

6 CHAIRWOMAN OLSON: Thank you.

7 Next. Did you sign in?

8 MS. MITCHELL: There's a sign-in sheet up
9 there.

10 CHAIRWOMAN OLSON: Go ahead.

11 MS. COLBY: Good morning. My name is
12 Ruth Colby. I'm the senior vice president of
13 business development and the chief strategy officer
14 at Silver Cross Hospital. I'm here to express the
15 support of Silver Cross Hospital for Alden Estates-
16 Courts of New Lenox, Project No. 15-051.

17 Alden and Silver Cross Hospital have had a
18 long and successful relationship. We currently
19 partner on the Centers for Medicare and Medicaid on
20 services bundled pilot program, which is improved
21 care for patients with heart failure, pneumonia, and
22 those that have had major joint replacements, and as
23 this Board probably knows, the bundled pilot program
24 requires that hospitals are responsible for the cost

1 of care for these patients 30 days after they leave
2 the hospital. So in partnering with Alden we have
3 identified wonderful skilled facilities that help us
4 manage the cost, improve the continuum of care, and
5 allover just improve overall health care for the
6 patients that we serve.

7 Having an Alden facility next door to our
8 hospital in New Lenox would be a great addition to
9 that medical hub that we've created in New Lenox.
10 It will offer close proximity for physicians to be
11 able to round on their patients that will be
12 residents at Alden, and it also offers easy access
13 for the patients that need to come over to the
14 hospital to see a physician or for outpatient testing.

15 So, in summary, Silver Cross supports this
16 project and the advantages it offers the community
17 and our patients, and we hope that the Illinois
18 Health Facilities and Services Review Board will
19 vote in favor of Alden Estates-Courts of New Lenox.

20 Thank you.

21 CHAIRWOMAN OLSON: Thank you.

22 MS. DYE: Good morning. I'm Nancy Dye, the
23 economic development coordinator for the Village of
24 New Lenox, and New Lenox wholeheartedly supports

1 Alden Estates-Courts of New Lenox, 15-051.

2 This is the first skilled nursing facility
3 in the village, and we are a growing community. We
4 have 26,000 residents in the village, another 15,000
5 in the township, and approximately 8 of -- 8 percent
6 of those residents are seniors. So as the
7 development coordinator, we do want to keep resident
8 services in New Lenox.

9 In addition, as far as being a growing
10 community, last year we had 167 housing permits, and
11 between yesterday and April 1st we have six new
12 businesses opening. So that brings seniors as well
13 as new residents to New Lenox.

14 This is an ideal location next to Silver
15 Cross Hospital. As Ruth stated, there are doctors'
16 offices and other facilities where the residents
17 won't have to travel far.

18 The Village has met several times with the
19 Alden representatives. In fact, our Village
20 administrator, Kurt Carroll, was the administrator
21 in Shorewood, Illinois. So he has firsthand
22 experience in not only working with Alden but seeing
23 the quality product that they bring to a community.

24 The project will create over 100 full-time

1 jobs and even additional jobs during the construction
2 of this development.

3 On a personal note I will tell you I've had
4 a mother-in-law and mother both with broken hips,
5 both who could not stay in the hospital for physical
6 therapy, and I assure you their angst would have
7 been much less had they been able to go to a
8 facility that was very close to the hospital where
9 their surgery took place.

10 We, therefore, in addition to myself
11 personally, support this project and hope that you
12 will approve it today.

13 CHAIRWOMAN OLSON: Thank you.

14 MS. STRENG: Good morning. My name is
15 Hadley Streng; H-a-d-l-e-y, S-t-r-e-n-g and I am
16 vice president of strategy and development at
17 Centegra Health System. I am here in support of
18 Transformative Health of McHenry's certificate of
19 need to establish a 98-bed skilled nursing facility
20 in McHenry, Illinois, Project No. 15-044.

21 Over a year ago Centegra Health Systems
22 solicited proposals from potential partners to
23 create an acute care facility -- sorry -- postacute
24 care facility on the campus of Centegra Hospital

1 McHenry to meet the identified bed need in the area.
2 The applicant was a successful respondent, and
3 Centegra strongly supports this project.

4 Since then, in October 2015 the bed need was
5 updated to show even a greater need for long-term
6 care beds in HSA 8 McHenry from 98 beds to 127 beds.

7 We strongly support the proposed project and
8 encourage the Illinois Health Facilities and
9 Services Review Board to approve this project. We
10 believe it will greatly enhance accessibility to
11 skilled nursing and postacute care services in
12 HSA 8, a need the Illinois Health Facilities and
13 Services Review Board has identified.

14 Thank you.

15 CHAIRWOMAN OLSON: Thank you.

16 Next.

17 DR. NATHAN: Good morning. My name is
18 Dr. Kumar Nathan; K-u-m-a-r, N-a-t-h-a-n, and I'm
19 senior vice president of clinical effectiveness at
20 Centegra Health System. I'm board certified in
21 internal medicine and established a hospitalist
22 group at Centegra Hospital in McHenry. In addition
23 to my administrative role, I am also a practicing
24 physician and care for patients at our hospital as a

1 hospitalist. I'm here in support of the
2 Transformative Health McHenry certificate of need
3 application, Project No. 15-044.

4 Hospitals in the United States are focused
5 on providing high-quality care effectively and
6 efficiently. We have been challenged, among other
7 things, to transition our patients appropriately when
8 they're ready to leave the hospital and to control
9 health care costs related to hospital readmissions.

10 To help meet these challenges, formal and
11 informal partnerships and integrated provider
12 relationships are becoming essential between hospitals
13 and postacute care providers. We are working together
14 to favorably impact quality, patient outcomes, and
15 overall costs through more effective care coordination.

16 The proposed project is designed to meet the
17 growing needs of patients requiring rehabilitation,
18 medical, and physician services as they are
19 transitioned from the hospital to their homes. I
20 strongly support the proposed project and encourage
21 the Illinois Health Facilities and Services Review
22 Board to approve the project.

23 Thank you.

24 CHAIRWOMAN OLSON: Thank you, Doctor.

1 Next five, Jeannie.

2 MS. MITCHELL: Next five are Kimberly Boike,
3 Clare Connor, Amrit Jacob, Kathy Miller, and Joyce
4 Surdick.

5 Please remember to sign in and spell your name
6 for the court reporter before you begin speaking.

7 You may begin speaking.

8 MR. JACOB: Good morning. My name is Amrit,
9 A-m-r-i-t; Jacob, J-a-c-o-b. I'm the administrator
10 of Crystal Pines Rehabilitation and Health Care
11 Center. I'm here to strongly oppose Transformative
12 Care Project No. 15-044.

13 This project does not meet any of the
14 criteria established by this body. This application
15 will divert existing referrals from all of us already
16 providing the same services in the same service area
17 without a demonstrated need for additional beds,
18 and, if approved, our facility will see 100 percent
19 decline in our short-term postacute patients, which
20 makes up 20 percent of our daily census.

21 Crystal Pines is a 118-bed licensed skilled
22 nursing facility with an average daily census of 95.
23 Crystal Pines has made capital improvements over the
24 past 30 months totaling \$350,000, and we're going to

1 be spending an additional \$150,000 this spring on
2 improvements, as well. This would involve the
3 recent expansion of our parking facilities due to
4 the increased number of visitors for our growing
5 short-term rehab programs.

6 In addition to turning a blind eye towards
7 servicing any of the Medicaid population which makes
8 up more than 60 percent of all skilled nursing beds
9 in Illinois, this applicant attempted to brush aside
10 how they'll meet the staffing needs for this
11 project. Staffing shortages are a major issue for
12 health care and skilled nursing facilities, and when
13 the latest rules for certificate of need were revised,
14 they incorporated staffing impact on competitors as
15 a key component of their consideration in reviewing
16 such applications.

17 In closing let me reiterate our opposition
18 to Project No. 15-044, and we respectfully urge you
19 to deny said application.

20 CHAIRWOMAN OLSON: Thank you.

21 Next.

22 MS. SURDICK: Good morning.

23 I'm Joyce Surdick, S-u-r-d-i-c-k, from Fair
24 Oaks Health Care Center in Crystal Lake, and I'm

1 here to present my opposition to the Transformative
2 Care Project No. 15-044.

3 Fair Oaks a 51-bed not-for-profit skilled
4 nursing facility in Crystal Lake. In my 19 years
5 there I've seen many changes, but the most
6 significant affecting our practice has occurred in
7 the last couple of years. CMS has changed the
8 landscape of long-term care and rehab with the
9 Bundled Payments for Care Improvement. They have
10 instituted programs for quality improvement and
11 shorted length of stays. There's been a push for
12 community-based care in homes.

13 Our average length of stay has gone from
14 27 in 2014, 22 in 2015, to a current 12-day average.
15 This obviously means I need to admit at least twice
16 as many people to maintain the 81 percent occupancy
17 I had in 2015.

18 We currently have 6,091 certified beds in a
19 25-mile radius, with 752 of them in a 10-mile radius
20 of Fair Oaks. Now with the addition of Alden Huntley
21 there will be another 110-bed facility 10 miles from
22 Fair Oaks. It has only been with our positive
23 institution of bundled payments patients that we
24 have started to see a change in 2016.

1 Our main referral source for rehab patients
2 are the two Centegra campuses in McHenry and
3 Woodstock. With Centegra Hospital opening their new
4 campus in Huntley, it is probable that the majority
5 of Woodstock rehab patients will go to that hospital
6 for surgery and do rehab at the new SNF in Huntley
7 due to open in 2017, leaving with us with the
8 McHenry campus as our main source of referrals.

9 If Transformative Care is allowed to open a
10 new facility, it is very probable it would be the
11 demise of Fair Oaks. It is obvious to us that
12 McHenry Centegra will be referring to the facility
13 in their own back yard. CMS has always resorted to
14 soft sells for filling buildings, but with the
15 advent of bundled payments and cost share, the hard
16 sell will be allowed in the not too far distant
17 future.

18 As far as serving the Medicare population,
19 our little 51-bed home supports 8 Medicaid beds,
20 which is 15 --

21 MR. AGBODO: Two minutes.

22 MS. SURDICK: -- percent of our total census
23 if we have a full house.

24 CHAIRWOMAN OLSON: Please wrap up your

1 comments. Your two minutes are up.

2 MS. SURDICK: I'm sorry. What?

3 CHAIRWOMAN OLSON: You need to wrap up your
4 comments; your two minutes are up.

5 MS. SURDICK: Okay.

6 It is my hope the Board will see the
7 necessity to deny this application and to let the
8 current area facilities continue to do the
9 outstanding job they have done for so many years.

10 Thank you for your consideration.

11 CHAIRWOMAN OLSON: Thank you.

12 Next.

13 MS. MILLER: My name is Kathy Miller. I'm
14 here to oppose the Transformative Care Project
15 No. 15-044.

16 I'm from the Florence Nursing Home in
17 Marengo, Illinois. We're a four-star out of five
18 facility located in the market area. We offer long
19 and short-term care to our community.

20 Currently we're at 80 percent utilization,
21 which is common, leaving us 20 percent of our beds
22 open. We started out with 4 Medicaid beds and saw a
23 large need in the community for more, so we average
24 out of 56 beds, 28 of those are currently for

1 Medicaid. So in order to succeed and take care of
2 the patients that we need to and provide that
3 quality of care, we need those Medicare beds also
4 filled.

5 So three-quarters of our referrals come from
6 Centegra Hospital. And those we appreciate but,
7 again, as others have stated, if this 96-bed
8 facility is opened, we'll surely feel that effect,
9 which could absolutely close our doors.

10 Alden in Huntley we never opposed is a
11 110-facility which is to open in this next year.
12 Huntley is where Florence draws a lot of our
13 admissions, whether it's for Medicare or long-term
14 patients. It's close in proximity. So once that
15 building opens, we'll no longer get those admissions.

16 So the current market in this area has
17 plenty of availability and capacity to meet the
18 needs of our community now and in the future, so we
19 definitely oppose this Transformative Care project.

20 Thank you.

21 CHAIRWOMAN OLSON: Thank you.

22 MS. RANALLI: Good morning. My name is
23 Clare Connor Ranalli, and I'm legal counsel to
24 various facilities that you've heard from here today

1 and for some facilities that you will hear from
2 shortly. I'm also speaking in opposition to
3 Project 15-044, Transformative Health Care McHenry.

4 The applicants have submitted an application
5 to you on the basis of alleged need in McHenry County.
6 That need is actually undercut by two arguments.

7 First, as you've heard and as you will
8 continue to hear, there is more than enough capacity
9 to serve long-term care patients in McHenry County.

10 Also, the county borders are somewhat of a
11 misnomer because many of the facilities, including
12 one you will hear from, is within 10 minutes of the
13 proposed facility and offers the exact same services.
14 And that latter point is important because the bed
15 need that you have for McHenry County is based on
16 general long-term care beds. So we think that the
17 traditional long-term care patient, a nursing home
18 type of patient, that there are also long-term care
19 beds that are reserved for subacute rehab patients.
20 Those patients are primarily Medicare and commercial
21 pay patients. They are the crème de la crème of the
22 payor source for long-term care facilities.

23 The proposed facility will offer services,
24 according to the application, only to subacute

1 patients, not to general long-term care. So if the
2 application is approved, the general long-term care
3 bed need will be almost completely taken up with
4 special care beds for subacute rehab patients,
5 leaving no room for general long-term care beds in
6 the service area and duplicating services that
7 already exist at various facilities. 9 and 11 are
8 under your target capacity and offer the same
9 services and also serve Medicaid patients.

10 Therefore -- and, also, I would like to
11 point out that there was an application --

12 MR. AGBODO: Two minutes.

13 MS. RANALLI: -- that has been denied --

14 CHAIRWOMAN OLSON: Please conclude your
15 remarks.

16 MS. RANALLI: There was an application
17 denied in the same service area because of the
18 duplication of services. That application is
19 currently in court. They're challenging a court
20 order --

21 CHAIRWOMAN OLSON: I need you to finish.

22 MS. RANALLI: All right. I'll conclude
23 then. Thank you very much.

24 CHAIRWOMAN OLSON: Next.

1 MS. MITCHELL: The next five are Don Reppy,
2 Andrew P. Tecson, Aaron Topper, Mark Weldler, and
3 Astrid Larsen.

4 Again, please remember to sign in and to
5 spell your name before you begin speaking for the
6 court reporter.

7 MR. TECSON: Good morning. Andrew Tecson,
8 T-e-c-s-o-n. I'm presenting testimony in opposition
9 to Project 15-044, Transformative Health of McHenry,
10 on behalf of ManorCare Health Services, HCR ManorCare,
11 and ManorCare Health Services Libertyville.

12 Transformative's application fails to meet
13 several requirements of this Board. Service
14 accessibility, unnecessary duplication/maldistribution,
15 and impact on other area providers. I'll refer to
16 these as the duplication and impact standards.

17 On November 13th, 2015, McHenry County Court
18 instructed this Board to issue a CON for 130 beds to
19 ManorCare. This completely eliminates the 127-bed
20 need in McHenry County, which means there's no need
21 for Transformative's project.

22 Finally, Transformative failed to provide
23 any referral letters that meet the Board's requirements
24 as none of those letters commit to make any

1 referrals to Transformative Health.

2 The McHenry County court order relates to a
3 CON application filed by ManorCare in 2012 to build
4 a 130-bed skilled nursing facility in McHenry
5 County. In 2012 there was a projected need in
6 McHenry County far in excess of the 130 requested
7 beds. This Board denied ManorCare's application
8 despite the bed need and based on the same
9 duplication and impact standards that Transformative
10 does not meet.

11 McHenry appealed that decision, and on
12 November 13, 2015, McHenry Court issued an order
13 holding that the denial of ManorCare's application
14 for a CON was as a matter of law contrary to the
15 manifest weight of the evidence and arbitrary and
16 capricious. McHenry Court remanded the order to
17 this Board with instructions to issue the
18 certificate of need to ManorCare.

19 The Board's appeal of the court order
20 indicates that the Board does not believe that the
21 130 beds of the ManorCare project are needed in
22 McHenry County. There is no basis for the Board to
23 view the Transformative application more favorably
24 than the ManorCare application, and Transformative's

1 should be denied.

2 MR. TOPPER: Good morning. My name is
3 Aaron Topper, T-o-p-p-e-r, and I thank you for
4 listening to my comments in opposition to
5 Project 15-044, Transformative Care of McHenry County.

6 I am the owner of Crossroads Care Center of
7 Woodstock, a 115-bed skilled nursing facility in
8 Woodstock. Over 85 percent our business comes from
9 Centegra Hospital System. I have expanded the
10 services that we offer numerous times and invested
11 well over \$3 million in capital improvements to my
12 facility in order to address the needs of the
13 community and hospital discharges.

14 All of these charges and improvements have
15 come from the dialogue that I have had personally
16 with staff and executives at the hospital. My
17 facility on average runs 80 percent occupancy, which
18 is below your occupancy target. We have focused
19 very hard and worked tirelessly to maintain these
20 numbers and have not seen them increase in over
21 three years. Regardless of what the projections may
22 say, statistics on the ground tell us that skilled
23 nursing needs have not increased in over three years.

24 Unless we can maintain what we have,

1 especially the Medicare population, we would have a
2 very difficult time and likely not be capable of
3 maintaining profits, let alone having the ongoing
4 capital we need to continue to invest in our
5 facility on a regular basis.

6 The Transformative Care project by its very
7 admission will also see most of the exclusive
8 Medicare recipients for short-term care rehab. We
9 have always been one of the only facilities in the
10 area to accept many of the charity cases that the
11 hospital has not been able to place due to lack of
12 funding or difficulties in care levels. It is our
13 belief that in order to appropriately partner and
14 service a community in the primary hospital system
15 we need to be willing to accommodate for all the needs
16 of all the patients whenever and wherever possible.

17 In summary, we have the capacity to handle
18 any increase in need that may arise in the county.
19 We offer the services that the hospital has
20 consistently communicated to us are needed and are
21 always willing to expand these services further
22 whenever the need should arise. If a new facility
23 were to be opened with the clear motive to cater
24 strictly to the high-end, short-term Medicare

1 residents --

2 MR. AGBODO: Two minutes.

3 MR. TOPPER: -- and only admit those
4 patients, it would significantly limit --

5 CHAIRWOMAN OLSON: Please conclude your
6 comments.

7 MR. TOPPER: -- my facility's ability to
8 operate in the market.

9 Thank you.

10 MR. WELDLER: Good morning. My name is
11 Mark Weldler, W-e-l-d-e-r, from The Springs at Crystal
12 Lake, and I'm here in opposition to Transformative
13 Health Care in McHenry Project No. 15-044.

14 The Springs is a 97-bed facility which
15 historically has provided high-quality services with
16 excellent outcomes to the community. We're a four-
17 star facility on the Medicare.gov website. We are
18 Joint Commission accredited, and we provide -- we
19 specialize in posthospital short-stays. The
20 majority of the people with us are in that category
21 for everything from postorthopedics, wound care
22 management; we have cardiology on staff; we have --
23 many of the physicians in the area are routinely in
24 our facility. We have on-site dialysis, and we have

1 many other complex services needed for patients'
2 posthospital stays.

3 The applicant states that their referrals
4 will be coming from Centegra Hospital, which I want
5 to point out is the hospital that's -- in the area
6 that's the hospital we get our referrals from. Over
7 90 percent of our referrals come from that hospital.
8 The applicant states that of the traditional amount
9 of referrals that the hospital gives out to
10 facilities to SNFs, that go to SNFs, they will take
11 approximately 30 percent acknowledged. The rest
12 they say will be for the other facilities. So in
13 their own terms they're taking 30 percent of what is
14 now being directed to other facilities.

15 We haven't seen growth in any of the numbers
16 in the past few years. Our facility -- just as a
17 comparison, they're stating 30 percent. If we even
18 take 10 percent of that, that's our utilization
19 which is now at 65 percent even lower.

20 They claim that they only need 561
21 admissions --

22 MR. AGBODO: Two minutes.

23 MR. WELDLER: -- to meet targetization.

24 That requires a length of stay of 58 days.

1 CHAIRWOMAN OLSON: I need you to conclude.

2 MR. WELDLER: Thank you very much.

3 CHAIRWOMAN OLSON: Thank you.

4 MR. WELDLER: I would just like to say that
5 I'm pleading with the Board to please consider that
6 the math does not add up, and the length of stay
7 they will need will be far more than that.

8 Thank you.

9 MS. LARSEN: Good morning. I'm Astrid
10 Larsen; A-s-t-r-i-d, L-a-r-s-e-n. I'm the director
11 of care coordination for Centegra Health System.

12 The care coordination team at Centegra Health
13 System is responsible for the safe and efficient
14 transition of our patients from the hospital setting
15 to their next level of care. I am here in support
16 of Transformative Health in McHenry's certificate of
17 need application, Project No. 15-044.

18 Our care coordination team works with
19 patients, their families, and community providers to
20 create the strongest and safest discharge plan
21 possible. In order to ensure all of these parties
22 are working in concert, we have created a transition
23 of care committee that includes all of our postacute
24 care providers. This group collaborates to define

1 transfer expectations which include quality outcomes.
2 The applicant will be welcomed into this transition
3 of care committee and expected to meet the quality
4 the expectations of Centegra Health System.

5 In our region our care coordination team
6 faces difficulty as it works to ensure safe discharge
7 of our patients to postacute care facilities. There
8 are fewer available beds, patients have insurance
9 concerns, and at times we are forced to place a
10 patient in a facility that is not near family
11 members or friends who would be able to support
12 their recovery. Often bed availability is capped
13 for various reasons.

14 In this new era of health care, the majority
15 of care has transitioned into community settings.
16 Centegra Health System must have strong partners to
17 address population health and bundled payment
18 initiatives. Together we will create a healthier
19 community and improve patient satisfaction. We
20 believe the applicant's project will help us meet
21 our shared goals.

22 I strongly support this project as it
23 addresses these concerns in addition to the expected
24 increased need for an additional 127 beds in our area.

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Thank you.

CHAIRWOMAN OLSON: Thank you.

Next.

MS. MITCHELL: That's it.

CHAIRWOMAN OLSON: That concludes public participation.

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CHAIRWOMAN OLSON: The next item of business is items approved by the Chairwoman.

Mr. Constantino.

MR. CONSTANTINO: Madam Chairwoman, I was wondering if it be possible we just include that into the record rather than me read off the 29 items.

CHAIRWOMAN OLSON: Yes. You have in front of you the list of 29 items that were approved on page 5 of the agenda -- page 5 of your agenda.

May I have a motion to incorporate items approved by the chairwoman as listed on page 5 of the February 16th, 2016, HFSRB agenda?

MEMBER BURZYNSKI: So moved.

MEMBER JOHNSON: Second.

CHAIRWOMAN OLSON: All those in favor say aye.
(Ayes heard.)

CHAIRWOMAN OLSON: Opposed, like sign.
(No response.)

CHAIRWOMAN OLSON: The motion carries.
Thank you.

(Items approved by the Chairwoman are attached as follows:)

1. Permit Renewal #11-104 - McAllister

1 Nursing & Rehabilitation (6-Month Renewal 1/31/16 to
2 7/31/16)

3 2. Permit Renewal #15-005 - Presence Lakeshore
4 Gastroenterology (18-Month Renewal 12/31/15 to
5 6/30/2017)

6 3. Permit Renewal #14-019 - FMC Summit
7 (12-Month Renewal 12/31/15 to 12/31/16).

8 4. Permit Renewal #14-012 - FMC Gurnee
9 (12-Month Renewal 12/31/15 to 12/31/16).

10 5. Permit Renewal #13-036 - Touchette Regional
11 Hospital (4-Month Renewal 12/31/15 to 4/30/16).

12 6. Permit Renewal #13-034 - St. Elizabeth's
13 Hospital (4.5 Month Renewal 1/15/16 to 5/31/16).

14 7. Permit Renewal #13-047- Midwestern Regional
15 Medical Center (9-Month Renewal 12/31/15 to 9/30/16).

16 8. Permit Renewal #14-020 - DaVita Chicago
17 Ridge Dialysis (3-Month Renewal 1/31/16 to 4/30/16).

18 9. Permit Renewal #13-069 - Memorial Hospital
19 Carbondale (12-Month Renewal 12/31/17 to 12/31/18).

20 10. Permit Renewal #15-024 - Fresenius
21 Medical Care Chicago (11-Month renewal 01/31/2013 to
22 12/31/2016).

23 11. Permit Alteration #13-072 - NorthPointe
24 Health & Wellness Campus ASTC Space/Cost Reallocation.

1 12. Permit Alteration #13-069 - Memorial
2 Hospital-Carbondale (6.8% cost increase \$52,495,838
3 to \$56,112,398).

4 13. Permit Alteration #14-013 - The University
5 of Chicago Medical Center Increase Costs.

6 14. Exemption #E-034-15 - Centegra Hospital
7 Huntley - Change of Ownership.

8 15. Exemption #E-035-15 - Marianjoy
9 Rehabilitation Hospital - Change of Ownership.

10 16. Exemption #E-037-15 - Memorial Hospital
11 Belleville - Discontinue 14-Bed Pediatrics Service.

12 17. Exemption #E-038-15 - Midwest Center for
13 Day Surgery - Change of Ownership.

14 18. Exemption #E-001-16 - Provident Hospital -
15 Discontinue 23-bed Obstetric Category of Service.

16 19. Exemption #E-002-16 - Aledo Kidney Center -
17 Change of Ownership.

18 20. Exemption #E-003-16 - Dixon Dialysis
19 Center - Change of Ownership.

20 21. Exemption #E-004-16 - Quad Cities Kidney
21 Center, LTD Geneseo - Change of Ownership.

22 22. Exemption #E-005-16 - Quad Cities Kidney
23 Center, LTD Moline - Change of Ownership.

24 23. Exemption #E-006-16 - Quad Cities Kidney

- 1 Center Rock Island, LLC - Change of Ownership.
- 2 24. Exemption #E-007-16 - Quad Cities Kidney
- 3 Center Silvis, LLC - Change of Ownership.
- 4 25. Exemption #E-009-16 - Community Memorial
- 5 Hospital - Change of Ownership.
- 6 26. Exemption #E-010-16 - Heartland Regional
- 7 Medical Center - Discontinue Open Heart Surgery.
- 8 27. Project #15-057 - Fresenius Medical Care
- 9 Spoon River, Add 3 ESRD Stations.
- 10 28. Relinquishment of Permit #95-082 - Carle
- 11 Surgicenter- Champaign Post Recovery Care Center.
- 12 29. Relinquishment of Permit #97-106 - Carle
- 13 Surgicenter - Danville Post-Recovery Care Center.
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CHAIRWOMAN OLSON: The next item of business is items for state board action. First, we have permit renewal request.

The first item is A-01, 12-032, Alden Courts of Shorewood in Shorewood for a 13-month renewal from November 30th, 2015, to December 31st, 2016.

May I have a motion to approve this 13-month permit renewal for Alden Courts of Shorewood?

VICE CHAIRMAN HAYES: So moved.

CHAIRWOMAN OLSON: And a second?

MEMBER MCGLASSON: Second.

CHAIRWOMAN OLSON: And the applicant will come to the table.

Please state your name and be sworn in for the court reporter.

MS. SCHULLO: Randi Schullo.

MR. KNIERY: John Kniery, K-n-i-e-r-y.

(Two witnesses sworn.)

CHAIRWOMAN OLSON: Mr. Constantino, your report.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The applicants were approved to add 50 long-term beds to Alden Courts of Shorewood in

1 July of 2012. Their current completion date is
2 November 30th, 2015. This is a second permit
3 renewal request.

4 They're asking for a completion date of
5 December 31st, 2016. The reason for the delay was
6 HUD approval and architectural drawings were delayed
7 in both of those items.

8 Thank you, Madam Chairwoman.

9 CHAIRWOMAN OLSON: Thank you, Mike.

10 Comments for the Board?

11 MS. SCHULLO: Good morning, Madam Chair,
12 Members of the Board. I'm Randi Schullo, president
13 of Alden Management Services.

14 CHAIRWOMAN OLSON: Can you speak right into
15 the microphone?

16 MS. SCHULLO: With me today, John Kniery,
17 our CON consultant. Can you hear me okay?

18 CHAIRWOMAN OLSON: Go ahead.

19 MS. SCHULLO: We are here to ask for your
20 approval for a permit renewal until the end of this
21 year for our project in Shorewood.

22 We are pleased to report that construction
23 is well underway, roof trusses are up, and we will
24 be completely under roof within the next few weeks.

1 We expect to have construction complete this fall
2 and have a request for this project of a completion
3 date of December 31st to allow for completion of the
4 final project report.

5 We thank the Board for its consideration and
6 would be pleased to answer any questions you may have.

7 CHAIRWOMAN OLSON: Thank you.

8 Questions from Board members?

9 (No response.)

10 CHAIRWOMAN OLSON: My only question is, is
11 13 months going to be enough to do this? Have you
12 factored in your surveys and your approvals?

13 MS. SCHULLO: We believe -- construction is
14 targeted to finish September, late September, so we
15 think December should be sufficient, but if you
16 would like to add on a month or two, that would be
17 fine, as well.

18 CHAIRWOMAN OLSON: That's your choice.

19 MS. SCHULLO: We're comfortable with
20 December 31st.

21 CHAIRWOMAN OLSON: Okay. Other questions or
22 comments from Board members?

23 (No response.)

24 CHAIRWOMAN OLSON: Seeing none, I would ask

1 for a roll call vote on Project 12-032 for the
2 permit renewal request.

3 MR. ROATE: Senator Burzynski.

4 MEMBER BURZYNSKI: Aye.

5 MR. ROATE: Senator Demuzio.

6 MEMBER DEMUZIO: Aye.

7 MR. ROATE: Justice Greiman.

8 MEMBER GREIMAN: Aye.

9 MR. ROATE: Mr. Hayes.

10 VICE CHAIRMAN HAYES: Aye.

11 MR. ROATE: Mr. Johnson.

12 MEMBER JOHNSON: Aye.

13 MR. ROATE: Mr. McGlasson.

14 MEMBER MCGLASSON: Aye.

15 MR. ROATE: Mr. Sewell.

16 MEMBER SEWELL: Aye.

17 MR. ROATE: Madam Chair.

18 CHAIRWOMAN OLSON: Aye.

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

20 CHAIRWOMAN OLSON: The motion passes.

21 MS. SCHULLO: Thank you.

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CHAIRWOMAN OLSON: Next we have A-02,
Project No. 12-076, Chicago Surgical Clinic, Ltd, in
Arlington Heights for a six-month renewal from
December 31st, 2015, to June 30th, 2016.

May I have a motion to approve the six-month
permit renewal?

MEMBER DEMUZIO: Motion.

MEMBER JOHNSON: Second.

MEMBER GOYAL: Madam Chair, I'm an ex-officio;
I do not vote but I would like to declare my
potential conflict since I worked with Dr. Levitin.

CHAIRWOMAN OLSON: Thank you.

Would you please be sworn in for the court
reporter.

State your names.

DR. LEVITIN: Yelena Levitin, L-e-v-i-t-i-n.

MS. PAIGE: Billie Paige, P-a-i-g-e.

(Two witnesses sworn.)

CHAIRWOMAN OLSON: Mr. Constantino, State
Board staff report.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The applicants were approved to establish a
multispecialty ASTC in December of 2012. Their

1 current completion date is December 31st, 2015.
2 This is the third permit renewal request for this
3 project. They're asking for a completion date of
4 June 30th, 2016.

5 Thank you, Madam Chairwoman.

6 CHAIRWOMAN OLSON: Comments for the Board.

7 MS. PAIGE: Good morning, Madam Chair and
8 Board members. My name is Billie Paige. I'm a
9 consultant on this project representing Dr. Yelena
10 Levitin, who is seated to my left. I am with the
11 firm of Shea, Paige & Rogal.

12 Let me just quickly, hopefully, say to you
13 that the reason we need this third renewal is the
14 fact that we simply ran out of time in which the
15 Department of Public Health could come in and tell
16 us what, if anything, was wrong with the project.

17 We are about 97 percent complete. We have
18 gotten our first inspection from the Department of
19 Public Health, which I believe is attached to our
20 submission. There are 15 items on that list. We
21 are in the process now of going through that and
22 getting all of those items done with.

23 Unfortunately, we couldn't get it done
24 before December 31 of this past year, so we had to

1 come and ask you for another permit renewal through
2 June 30th of this year.

3 We believe that by June the 30th we will not
4 only have met your deadline, but we will be fully
5 licensed and opened doing business.

6 CHAIRWOMAN OLSON: Questions from Board
7 members?

8 (No response.)

9 CHAIRWOMAN OLSON: I actually have a question.
10 When I look at this page, the one that you
11 referred to with the 15 items on it, and you as look
12 at some of those items, I mean, some of these are
13 big things like moving walls and making bathrooms
14 that aren't accessible accessible.

15 And so I'm just wondering where you are at
16 on that list because it seems to me that's going to
17 require structural changes, and I'm concerned that
18 June 30th of this year is not going to be enough time.

19 MS. PAIGE: I have been informed -- and I
20 have both the facility manager and our attorney
21 sitting behind us, but I have been informed by them
22 that much of -- several pieces have already been done,
23 including the structural things that you are talking
24 about that. Evidently they were in the process but

1 not completed, and if they're not completed, the
2 Department tells you you've got to do them.

3 So I'm not sure in what stage of development
4 any of them were, but I am reliably informed --
5 because, like you, I would hope not to have to come
6 back, but I feel very comfortable that by June 30th
7 of this year this facility will be complete and open.

8 CHAIRWOMAN OLSON: Other questions?

9 MEMBER DEMUZIO: Just to kind of piggyback
10 on that, I'm a little concerned about No. 15 on that
11 list. That's the handicap accessible patients which
12 are coming out of recovery room. Can you tell me
13 where you're at?

14 MS. PAIGE: Yes, Senator Demuzio, so was I,
15 and it's the one item on this list that I've
16 personally been involved in.

17 MEMBER DEMUZIO: I know.

18 MS. PAIGE: And I am told -- and I have
19 asked about this. They have been in touch with the
20 gentleman who is in charge of that over at the
21 capital development board.

22 MEMBER DEMUZIO: Okay.

23 MS. PAIGE: And he has indicated exactly
24 what he wanted. I am told that we have a letter

1 from him which we do not have with us indicating
2 what needs to be done. It's very much like the
3 15 points, and we will be doing that.

4 And I've been told that it's not structural
5 at all, which kind of surprised me because typically
6 it is a structural issue, but evidently these were
7 old bars and the like that are reasonably simple to
8 do. So it wouldn't take a lot of time.

9 MEMBER DEMUZIO: Can I make a request to
10 have you send that letter when you receive it?

11 MS. PAIGE: Absolutely.

12 MEMBER DEMUZIO: Can you send it to the
13 Board here --

14 MS. PAIGE: Absolutely.

15 MEMBER DEMUZIO: -- that No. 15 has been
16 taken care of?

17 MS. PAIGE: We will do that.

18 MEMBER DEMUZIO: Okay. Thanks.

19 CHAIRWOMAN OLSON: Other questions from the
20 Board members?

21 (No response.)

22 CHAIRWOMAN OLSON: Seeing none, I'll ask for
23 a roll call vote on Project 12-076 for permit
24 renewal.

1 MR. ROATE: Thank you, Madam Chair. Motion
2 made by Senator Demuzio, seconded by Mr. Johnson.

3 Senator Burzynski.

4 MEMBER BURZYNSKI: Yes.

5 MR. ROATE: Senator Demuzio.

6 MEMBER DEMUZIO: Yes.

7 MR. ROATE: Justice Greiman.

8 MEMBER GREIMAN: Yes.

9 MR. ROATE: Mr. Hayes.

10 VICE CHAIRMAN HAYES: Yes.

11 MR. ROATE: Mr. Johnson.

12 MEMBER JOHNSON: Yes.

13 MR. ROATE: Mr. McGlasson.

14 MEMBER MCGLASSON: Yes.

15 MR. ROATE: Mr. Sewell.

16 MEMBER SEWELL: Yes.

17 MR. ROATE: Madam Chair.

18 CHAIRWOMAN OLSON: Yes.

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

20 CHAIRWOMAN OLSON: Motion passes. Thank you.

21 We have no extension requests, no exemption
22 requests, no alteration requests, no declaratory
23 rulings, nothing under Health Care Worker
24 Self-Referral Act.

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CHAIRWOMAN OLSON: Under Status Reports on Conditional/Contingent Permits we have one, Apollo Surgical Center, Project 11-022, if they would please come to the table.

Would you please be sworn in.

(Two witnesses sworn.)

CHAIRWOMAN OLSON: Before you speak, I think Jeannie has some comments.

MS. MITCHELL: This is Apollo Surgical Center.

When their application was before the Board, they made representations as to what the facility would do, and based on the representations the Board agreed to approve this project.

There was a condition placed on the permit that 15 months after licensure the applicants would come back before the Board and explain whether they met the terms of those representations or not and explain why they did not if they failed to do so. So that's what they're here to do today.

Board members, you have before you a chart explaining the representations that they made and how their report compares to those representations.

1 CHAIRWOMAN OLSON: And I'd just like to say
2 that the Board is very anxious to hear what you have
3 to say because when we put conditions on permits we
4 take that very seriously. We don't want the
5 impression to be out there that you can just sit at
6 the table and say what it is you think we want to
7 hear and your project will be granted a permit and
8 then not follow through.

9 So we're anxious to hear what you have to say.

10 MS. SCHMIDT: Good morning, Chair Olson,
11 Board members, and staff. My name is Vera Schmidt.
12 I'm the chief executive officer of Apollo Surgical
13 Center, and I'd like to thank the Board for this
14 opportunity for us to come and answer any questions
15 you may have about our operations and charity
16 care work.

17 So I'd like to start with after being approved
18 to open our center in 2011, Apollo received its IDPH
19 license in March of 2014 and reported its payor mix
20 data for the first day of operations to the Board
21 last year.

22 As a general matter, we have had issues with
23 pro-life protestors who have been very vocal and
24 disruptive to our business. As some providers

1 became aware that the facility might provide
2 pregnancy terminations, they indicated they would
3 not want to bring their patients to this facility.
4 In July of 2014 Apollo decided they would not perform
5 pregnancy terminations because of the stigma it
6 creates. Patients requiring these services are now
7 referred to other centers that perform pregnancy
8 termination.

9 Beyond that key problem, the lead
10 gastroenterologist at Apollo has retired, and one of
11 the urologists fell seriously ill and is not
12 performing surgeries at the center. Additionally,
13 Apollo was not Medicare certified for most of 2015.
14 This not only impacted Medicare patients but also
15 patients with other insurance carriers. As an
16 example, we're still waiting for our Blue Cross/Blue
17 Shield contract which we could not apply for until
18 we received the Medicare certification.

19 We are continually recruiting physicians who
20 are committed to providing affordable health care as
21 well as charity care to underserved individuals. It
22 is our hope that we can achieve our goal of
23 increasing access to much-needed health care
24 services to the low-income and medically underserved

1 populations.

2 Thank you for your time and attention, and I
3 can answer any questions that you have --

4 CHAIRWOMAN OLSON: Questions from the Board
5 members?

6 Senator.

7 MEMBER DEMUZIO: Just a quick question. I
8 was looking through some things here. Can you tell
9 me how many Medicaid patients you have?

10 MS. SCHMIDT: Currently not Medicaid but
11 Medicare in 2015.

12 MEMBER DEMUZIO: So you have no certificate
13 for Medicaid?

14 MS. SCHMIDT: We are applying for Medicaid
15 at this time.

16 MEMBER DEMUZIO: And you haven't received
17 it yet?

18 MS. SCHMIDT: Not yet.

19 MEMBER DEMUZIO: Is there a reason at this
20 moment?

21 MS. SCHMIDT: Well, our biggest concern --
22 actually, the actual Medicare certification, but we
23 are working on --

24 MEMBER DEMUZIO: Medicare?

1 MS. SCHMIDT: Medicare.

2 MEMBER DEMUZIO: Okay. What about Medicaid?

3 MS. SCHMIDT: Medicaid we have an
4 application in.

5 MEMBER DEMUZIO: And how long has your
6 application been in?

7 MS. SCHMIDT: It's a couple months ago we
8 put it in.

9 MEMBER DEMUZIO: But you've been in
10 operation how long?

11 MS. SCHMIDT: We saw our first patients I
12 think in July of 2014.

13 MEMBER DEMUZIO: And you're just now
14 applying for that. Is there a reason why that's a
15 little later?

16 MS. SCHMIDT: Again, I think we were
17 focusing on AAA accreditation, Medicare, most of the
18 surgical center and just recently started working on
19 Medicaid.

20 MEMBER DEMUZIO: So how many patients do you
21 anticipate in your population from Medicaid?

22 MS. SCHMIDT: I don't have that number.

23 MEMBER DEMUZIO: Any idea?

24 MS. SCHMIDT: I don't have those numbers. I

1 just have our Medicare numbers from last year.

2 MEMBER DEMUZIO: How many Medicare?

3 MS. SCHMIDT: For 2015 we did 31 percent.

4 MEMBER DEMUZIO: 31 percent?

5 MS. SCHMIDT: Uh-huh.

6 MEMBER DEMUZIO: Okay. And you have not a
7 rough idea of Medicaid?

8 MS. SCHMIDT: No.

9 MEMBER DEMUZIO: All right. Thank you.

10 CHAIRWOMAN OLSON: Just to follow up on
11 that. You don't have any idea when you're going to
12 get the Medicaid certification?

13 MS. SCHMIDT: No.

14 CHAIRWOMAN OLSON: But you only filed it
15 two months ago?

16 MS. SCHMIDT: Yes.

17 CHAIRWOMAN OLSON: And is that because you
18 realized you weren't going to make your commitment
19 to the Board or -- I don't know why those couldn't
20 have been filed simultaneously. There's nothing
21 that says you can't file for Medicare while you
22 already -- or for Medicaid while you already have an
23 application to Medicare.

24 MS. SCHMIDT: Again, our biggest focus at

1 that time was with the AAA accreditation which we
2 had to do twice and the Medicare -- just getting the
3 Medicare.

4 CHAIRWOMAN OLSON: Do you anticipate any
5 issues with receiving your Medicaid certification?

6 MS. SCHMIDT: No.

7 CHAIRWOMAN OLSON: Other questions from
8 Board members?

9 MEMBER DEMUZIO: Just as a follow-up, I'm
10 hearing and I'm seeing something here that at the
11 time when you were applying you were going -- that
12 was your main focus was to do Medicaid, and when you
13 applied for this, now we're looking at what
14 three years later and you still don't have it. So
15 your testimony at the time apparently causes me a
16 little concern.

17 CHAIRWOMAN OLSON: So I'm wondering, can you
18 tell us what your current hours are?

19 MS. SCHMIDT: We're open Monday through
20 Friday. Our census is very low at this time because
21 of the issues I previously described.

22 We are in the position of right now
23 recruiting physicians, and there's two groups that
24 are very interested in coming on board. But right

1 now our census is very low. We still offer charity
2 care at discounted rates. 2014/2015 we offered that
3 to our patients.

4 CHAIRWOMAN OLSON: So I'm not sure if you
5 recall or not, but when the applicant was here
6 before, they committed to some evening hours and
7 Saturdays and Sundays, as well.

8 MS. SCHMIDT: Right. And if we had the
9 volume, we will be doing that. We just don't have
10 the volume.

11 CHAIRWOMAN OLSON: But that's not the way it
12 was presented. It was not presented that, "If we
13 have the volume, we'll do that." I understand what
14 you're saying, but, again, that's not the way it was
15 represented to the Board.

16 MS. SCHMIDT: If I had a physician that came
17 on board this week and said, "I want to do procedures
18 on Saturdays or in the evening," we would honor that.
19 It seems silly to keep the facility open with no
20 patients.

21 Now, this facility is open 8:00 to 4:30 every
22 day. There's some minimum staffing there. On days
23 when we do surgeries, then we have a lot of temporary
24 and leased employees that we bring in. So that's

1 how we're able to keep it under budget, but we bring
2 those employees in on surgical days.

3 CHAIRWOMAN OLSON: I think that's sort of a
4 chicken or an egg thing. If you don't have evening
5 hours or Saturdays or Sundays, you obviously don't
6 have the patients during those hours.

7 I understand what you're saying, but, again,
8 it goes back to the Board's discomfort with promises
9 being made that were not kept, and I guess maybe at
10 some level shame on us for thinking you would do the
11 things that you said you were going do but it's not
12 sitting well.

13 Other questions from Board members.

14 MEMBER GOYAL: Madam Chair, I have one.

15 You indicated that you applied for Medicaid
16 certification two months ago. Have you had since
17 the facility has been opened any Medicaid patients
18 that you turned down because of that?

19 MS. SCHMIDT: No.

20 MEMBER GOYAL: Thank you.

21 MS. SCHMIDT: If I could add to that, we have
22 a pain management physician who brings his patients
23 for injections. That's one of the procedures he does.
24 Some of those patients are Medicaid. And, actually,

1 even with the Medicare because we just recently got
2 certified, that he brought those patients and we
3 probably will not get reimbursed for those patients
4 because we weren't certified at the time. So that's
5 some additional charity care I guess you would
6 call it.

7 CHAIRWOMAN OLSON: Mr. Hayes, did you have a
8 question?

9 VICE CHAIRMAN HAYES: Yes. Thank you,
10 Madam Chairwoman.

11 Why hasn't your facility provided more
12 hardship discounts?

13 MS. SCHMIDT: Well, first of all, our census
14 across the board is very low, but we are providing
15 what we -- I believe we said we would provide
16 5 percent charity care, and last year we provided
17 16 percent charity care, and the year before that
18 was I think 19 percent. And as far as the patients
19 receiving the 80 percent discount, for last year it
20 was around 10 percent.

21 VICE CHAIRMAN HAYES: But in that respect
22 you had committed to 55 percent; is that correct?

23 MS. SCHMIDT: We did. But I think some of
24 those patients went over into the full charity. So

1 we offered more full charity rather than just
2 80 percent discount.

3 VICE CHAIRMAN HAYES: Okay. Another thing
4 is that -- now, your Medicare certification was only
5 gotten in what now -- in 2015; is that correct?

6 MS. SCHMIDT: Yes.

7 VICE CHAIRMAN HAYES: And what month was that?

8 MS. SCHMIDT: I was not working on the
9 application, so I can't say exactly when.

10 MS. MITCHELL: I believe it was October.

11 MS. SCHMIDT: It was October.

12 VICE CHAIRMAN HAYES: And why is it --

13 MS. SCHMIDT: I'm sorry. I'm sorry. October
14 is when we received the Medicare certification.

15 VICE CHAIRMAN HAYES: Why did it take so long?

16 MS. SCHMIDT: Well, if I look at our
17 timeline here, you know, you have to receive your
18 AAA accreditation first.

19 Our first application for AAA went in in May
20 of 2014, shortly after we received our license. We
21 had our first survey November of 2014, plan of
22 correction in January of 2015. Because there were
23 some life safety issues they -- we had to do another
24 survey that AAA had to come in again. So that

1 second survey didn't occur until June of 2015.

2 And all of these, as soon as we got one
3 report, we immediately completed our plan of
4 correction, sent it in. AAA actually worked with us
5 to try to rush things, so the accreditation actually
6 occurred in July of 2015, and then that's when
7 Medicare -- in October of 2015 we were certified.

8 VICE CHAIRMAN HAYES: Okay. Okay. Well, it
9 sounds like if -- you know, when you started -- this
10 facility has been open since June of 2014?

11 MS. SCHMIDT: Correct.

12 VICE CHAIRMAN HAYES: Wouldn't you want to
13 have your Medicare and Medicaid certifications as
14 soon as possible? And the Medicare took another,
15 what, 15 months?

16 MS. SCHMIDT: Yes. But we were actively
17 working on it the whole time, and it's because of
18 the AAA accreditation.

19 VICE CHAIRMAN HAYES: And what is the AAA
20 accreditation exactly?

21 MS. SCHMIDT: What is it? It's like Joint
22 Commission.

23 VICE CHAIRMAN HAYES: Okay.

24 MS. SCHMIDT: And we had to go through that

1 twice. So with the timeline -- you know, as soon as
2 we realized we had to do one thing or another we
3 would send the application in and pretty much wait
4 for them to come and survey.

5 MS. COOPER: Anne Cooper. I'm attorney for
6 the -- for Apollo.

7 The Medicare -- the initial application for
8 Medicare, part of it is you have to be surveyed in
9 order to be Medicare certified. There's what's
10 called deemed status. So, basically, in lieu of
11 IDPH or CMS coming in and surveying the facility,
12 AAA Joint Commission will come in, and they will
13 survey your facility.

14 Once you're accredited, you're given what's
15 called deemed status, and you don't have to go
16 through the survey process as part of your Medicare
17 application. So many providers will actually -- in
18 lieu of going through the survey process with CMS
19 will actually do it through AAA or Joint Commission
20 in order to get the deemed status so that their
21 Medicare application will actually go through the
22 pipeline a little bit faster.

23 In theory it's supposed to expedite the
24 Medicare application. In this case it did not

1 because, obviously, there were some deficiencies
2 that were cited in the AAA accreditation.

3 VICE CHAIRMAN HAYES: What did -- your
4 Medicare patients, what type of procedures are they
5 having there?

6 MS. SCHMIDT: This would be pain management,
7 injections, C-arm guided injections.

8 VICE CHAIRMAN HAYES: Now, why is your --
9 your private payor population has been 70.8 percent
10 in 2014 and then up to 49.3 percent in 2015.

11 MS. SCHMIDT: I'm sorry. The question is
12 why did it --

13 VICE CHAIRMAN HAYES: Why is it so high?

14 MS. SCHMIDT: Well, we were able to -- some
15 insurances were out of network. We were able to --
16 some of the insurances were paying out of network
17 for some patients, and our census is just down so
18 low that we're seeing whatever patients we can get
19 right now. And those that require charity care, we
20 offer charity care; if they need a discounted rate,
21 we offer discounted rates. If they have insurance
22 and if we can't -- even if we're out of contract with
23 someone, obviously, we don't take Blue Cross/Blue
24 Shield because we're out of contract, but we are

1 taking some of those patients as charity or with other
2 insurances if they're paying for out-of-contract
3 status.

4 VICE CHAIRMAN HAYES: And what would be the --
5 so this facility has a very low census?

6 MS. SCHMIDT: Correct.

7 VICE CHAIRMAN HAYES: You've been using
8 temporary employees sometimes to be able to staff
9 it. How do you plan a turnaround? What type of
10 things would you be doing to turn around this
11 facility? Because it certainly doesn't look like
12 it's financially strong right now.

13 MS. SCHMIDT: That is correct. We are working
14 with a management group to help recruit physicians.
15 So, basically, what we need to do is bring
16 physicians on.

17 As I mentioned before, we have two groups,
18 large groups -- one is a urology group and the other
19 is a pathology group -- that are very interested in
20 bringing their entire group on board and becoming
21 shareholders.

22 So that's where we are right now, just
23 hoping to go bring these other groups in who have
24 the same vision as we do, offer discounted rates,

1 and get the place moving, busy.

2 VICE CHAIRMAN HAYES: Thank you.

3 CHAIRWOMAN OLSON: Other questions?

4 Doctor.

5 MEMBER GOYAL: Thank you, Madam Chair.

6 One other question if you can answer. You had
7 committed to the Board to serve the underprivileged,
8 the uninsured, and medically underserved.

9 MS. SCHMIDT: Yes.

10 MEMBER GOYAL: Your charity care numbers
11 certainly are encouraging. However, I'm very
12 interested to know how you define charity care. Are
13 these people assigned to charity care upfront, or
14 are they assigned at the back end if they don't pay
15 their bills?

16 MS. SCHMIDT: Upfront. These would be
17 patients that are coming from different physicians'
18 offices that know that we offer this to them. So if
19 they have a patient that needs to have a procedure
20 done and they can't afford it, those offices actually
21 call us and ask us if we would offer that care.

22 MEMBER GOYAL: Thank you.

23 CHAIRWOMAN OLSON: Mr. Sewell.

24 MEMBER SEWELL: In your presentation earlier

1 you cited several reasons why your census was low.
2 You're not doing pregnancy terminations. I think
3 you mentioned a gastroenterologist or something.

4 MS. SCHMIDT: From the original application,
5 which was six years ago when we started this, he has
6 retired. One of the urologists is no longer doing
7 surgery, and some of the physicians that we did have
8 on board -- we actually had at one time three
9 credentialed gastroenterologists on board. Two left
10 the group -- did not want to bring cases, and the
11 other one also kind of went that route.

12 But it's been quite a bit of time since last
13 year. We're kind of doing a turnaround, so we're
14 looking -- we've had a lot of people very interested
15 in coming on board, and so we hope this is it.

16 MEMBER SEWELL: Overall could you tell us
17 what your utilization is in relation to what you're
18 projecting before all these things happen regardless
19 of payor class?

20 MS. SCHMIDT: I don't have a number but it's
21 extremely low. This is completely unforeseen for
22 us. We had no idea that we would run into this
23 problem and we did, and so we're just trying to
24 correct it now and trying to start fresh.

1 CHAIRWOMAN OLSON: So extremely low in that
2 there's potentially days where you have no cases?

3 MS. SCHMIDT: Yes.

4 CHAIRWOMAN OLSON: Other questions?

5 I guess I have one other question. I'm just
6 a little bit curious as to why -- you knew you had
7 this commitment to the Board -- why you never came
8 back to the Board or to our staff and say, "Look,
9 we're just not going to be able to make this and
10 what can we do about it?" I think that would have
11 helped your case.

12 MS. SCHMIDT: Because I think we can make --
13 we are running on a very tight budget. We are
14 making ends meet. Are we making a lot of profit?
15 No. We're just basically covering all our costs
16 right now. So all we need is a couple doctors to
17 get in there to turn things around for us.

18 CHAIRWOMAN OLSON: The Board will take all
19 of your comments here today under advisement, and
20 you will hear from our staff. We obviously wish you
21 success in continuing to turn this around. It may
22 be after the March meeting before you hear back from
23 us, but I would encourage you to try to continue to
24 turn things around mindful of the fact that you did

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make these promises to the Board.

MS. SCHMIDT: I understand.

CHAIRWOMAN OLSON: Thank you.

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CHAIRWOMAN OLSON: Next we have Applications Subsequent to Initial Review. The first group have no findings and no opposition.

First, we have Project H-01, 15-055 NorthShore University HealthSystem Niles. May I have a motion to approve Project 15-055 NorthShore University HealthSystem to establish a medical office building? May have a motion?

MEMBER SEWELL: So moved.

VICE CHAIRMAN HAYES: Second.

CHAIRWOMAN OLSON: Would you state your names and be sworn in for the reporter.

MR. AXEL: Jack Axel, Axel & Associates.

MS. PEREZ: Lynn Perez.

DR. REVIS: John Revis, internist and vice president.

(Three witnesses sworn.)

(Member McGlasson left the proceedings.)

CHAIRWOMAN OLSON: Mr. Constantino, your report.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The applicant is proposing to establish a medical office building in approximately 34,800 gross

1 square feet of space in Niles, Illinois. The
2 estimated project cost is \$13.8 million. The
3 anticipated completion date is December 31st, 2017.
4 There were no findings, no public hearing. No
5 opposition or support letters were received.

6 Thank you, Madam Chairwoman.

7 CHAIRWOMAN OLSON: So in light of the
8 positive State Board staff report, would you like to
9 make some comments, or would you like to open it up
10 to questions?

11 MR. AXEL: We would be happy to answer your
12 questions.

13 CHAIRWOMAN OLSON: Questions from Board
14 members?

15 (No response.)

16 CHAIRWOMAN OLSON: Seeing none, I will ask
17 for a roll call vote to approve Project 15-055,
18 NorthShore University HealthSystem in Niles to build
19 a new office building.

20 MR. ROATE: Thank you, Madam Chair. Motion
21 made by Mr. Sewell, seconded by Mr. Hayes.

22 Senator Burzynski.

23 MEMBER BURZYNSKI: Yes.

24 MR. ROATE: Senator Demuzio.

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MEMBER DEMUZIO: Yes.

MR. ROATE: Justice Greiman.

MEMBER GREIMAN: Yes.

MR. ROATE: Mr. Hayes.

VICE CHAIRMAN HAYES: Yes, based on the favorable State agency report.

MR. ROATE: Thank you.

Mr. Johnson.

MEMBER JOHNSON: Yes, based on the staff report.

MR. ROATE: Mr. McGlasson is absent.

Mr. Sewell.

MEMBER SEWELL: Yes. There were no findings.

MR. ROATE: Madam Chair.

CHAIRWOMAN OLSON: Yes, for the reasons stated.

MR. ROATE: That's 7 votes in the affirmative, 1 vote pass.

CHAIRWOMAN OLSON: The motion passes.

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CHAIRWOMAN OLSON: Next we have Project H-02, 15-047, NorthShore University HealthSystem Lincolnshire to build a medical office building.

May I have a motion to approve Project 15-047, NorthShore University Health System in Lincolnshire to build a medical office building? May I have a motion?

MEMBER DEMUZIO: Motion.

MEMBER JOHNSON: Second.

CHAIRWOMAN OLSON: Did I get a motion?

MEMBER SEWELL: The Senator.

CHAIRWOMAN OLSON: Oh. And we have a new gentleman. Would you please state your name and be sworn.

MR. MARK: My name is Jeffrey Mark, M-a-r-k.
(Witness sworn.)

CHAIRWOMAN OLSON: Mr. Constantino.

MR. CONSTANTINO: The applicant is proposing to establish a medical office building in 35,470 gross square feet of space in Lincolnshire, Illinois.

The total cost of the project is approximately \$15.4 million. The anticipated completion date is July 31st, 2017. There were no findings; no public

1 hearing was requested; no letters of support or
2 opposition were received.

3 Thank you, Madam Chairwoman.

4 CHAIRWOMAN OLSON: Thank you.

5 (Member McGlasson returned to proceedings.)

6 CHAIRWOMAN OLSON: In light of the favorable
7 staff report, do you have comments?

8 MR. MARK: Just quickly, Madam Chair, I'd
9 like to thank the Board staff for their assistance
10 in preparing this application and thank the Board
11 for its time considering.

12 CHAIRWOMAN OLSON: Questions and comments
13 from Board members?

14 (No response.)

15 CHAIRWOMAN OLSON: Seeing none --

16 VICE CHAIRMAN HAYES: Madam Chairwoman.

17 CHAIRWOMAN OLSON: Yes.

18 VICE CHAIRMAN HAYES: Now, NorthShore is in
19 merger talks with another health system, and what is
20 that health system?

21 MS. PEREZ: Advocate.

22 VICE CHAIRMAN HAYES: There is some with --
23 the Federal government, the Federal Trade Commission,
24 is it, that has raised some issues involved in that?

1 Is that correct?

2 MS. PEREZ: Yes, it is.

3 VICE CHAIRMAN HAYES: Now, what happens if
4 that merger does not go through that you're asked to
5 even divest some of your -- one of your hospitals or
6 it doesn't go through? Does this affect this
7 medical office building?

8 MS. PEREZ: From our perspective, no. This
9 is important to the patients that we serve and the
10 communities that we serve, and so we would be going
11 forward regardless.

12 VICE CHAIRMAN HAYES: And is there any -- I
13 notice that you have -- we just approved another
14 medical office building for you, and that's in the
15 North Shore area. Is there any other medical office
16 buildings that you -- will be coming before the Board?

17 MS. PEREZ: At this time, no.

18 VICE CHAIRMAN HAYES: Okay. Thank you.

19 CHAIRWOMAN OLSON: Other questions from
20 Board members?

21 (No response.)

22 CHAIRWOMAN OLSON: Seeing none, I'll ask for
23 a roll call vote on Project No. 15-047, NorthShore
24 University HealthSystem Lincolnshire for a medical

1 office building.

2 MR. ROATE: Thank you, Madam Chair. Motion
3 made by Senator Demuzio, seconded by Mr. Johnson.

4 Senator Burzynski.

5 MEMBER BURZYNSKI: Yes, based on staff's
6 findings.

7 MR. ROATE: Senator Demuzio.

8 MEMBER DEMUZIO: Yes, as they have met all
9 the criteria.

10 MR. ROATE: Justice Greiman.

11 MEMBER GREIMAN: Yes, based on what was set
12 forth previously.

13 MR. ROATE: Mr. Hayes.

14 VICE CHAIRMAN HAYES: Yes, based on the
15 favorable State agency report.

16 MR. ROATE: Thank you.

17 Mr. Johnson.

18 MEMBER JOHNSON: Yes, based on the State
19 agency report.

20 MR. ROATE: Thank you.

21 Mr. McGlasson.

22 MEMBER MCGLASSON: Yes, based on staff
23 findings.

24 MR. ROATE: Thank you.

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Mr. Sewell.

MEMBER SEWELL: Yes, based on State agency
report.

MR. ROATE: Madam Chair.

CHAIRWOMAN OLSON: Yes, for reasons stated.

MR. ROATE: 8 votes in the affirmative.

CHAIRWOMAN OLSON: The project passes.

MR. AXEL: Thank you.

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CHAIRWOMAN OLSON: Next we're going to go with our agenda alteration and hear Project H-09, 15-053, Rush University Medical Center in Chicago.

May I have a motion to approve Project 15-053, Rush University Medical Center master design project?

VICE CHAIRMAN HAYES: So moved.

MEMBER BURZYNSKI: Second.

CHAIRWOMAN OLSON: And second.

Mr. Constantino, your report.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

CHAIRWOMAN OLSON: That's H-09. We went out of order.

MR. CONSTANTINO: Rush University Medical Center is planning to expend funds in excess of the capital expenditure minimum for the purpose of renovating and reconfiguring facilities and services on the campus of Rush University Medical Center in Chicago. The total cost of the planning phase for this project is approximately \$32 million dollars.

Thank you Madam Chairwoman -- I'm sorry -- there were no findings, no public hearing, no opposition letters received.

Thank you, Madam Chairwoman.

1 CHAIRWOMAN OLSON: Do you have comments for
2 the Board, or would you like to open it to
3 questions? If you have comments, that's fine.

4 No questions -- oh, I'm sorry -- can you
5 swear them in?

6 THE COURT REPORTER: Will you raise your
7 right hands?

8 MR. DANDORPH: Michael Dandorph.

9 MS. RANALLI: Clare Ranalli.

10 (Two Witnesses sworn.)

11 CHAIRWOMAN OLSON: Open for questions or do
12 you have comments?

13 MR. DANDORPH: I'll just make a very brief
14 comment given the positive State Board report that I
15 do appreciate all the staff assistance that we had
16 with the application. And given the positive State
17 Board report, I'll limit my comments to that and
18 open it for any questions.

19 CHAIRWOMAN OLSON: Thank you.

20 Questions from Board members?

21 MEMBER GREIMAN: So where will students go
22 now that the housing would be taken down?

23 MR. DANDORPH: Currently we have about
24 125 students that will be affected by the

1 relocation. We're working with each one of those
2 students to identify alternative housing for them
3 before we demolish that --

4 MEMBER GREIMAN: Is there housing close by?

5 MR. DANDORPH: There are some options but
6 we're customizing that for each one of them. But we
7 do not have the other dormitories or student housing
8 on our campus.

9 MEMBER GREIMAN: So they'll lose the advantage
10 of living together and talking about their classes
11 and what they're doing. They'll lose that; right?

12 MR. DANDORPH: Right now those are each
13 individual units, so they're not really cohabiting
14 in the same way in terms of having that interaction,
15 but there's a number of options -- alternatives for
16 them to have that interaction on our campus in
17 student spaces. But for student housing they won't
18 have that opportunity to live right adjacent to the
19 university any longer.

20 VICE CHAIRMAN HAYES: Madam Chair, I was
21 reading in the paper that there is a plan on putting
22 200 or 300 units across the expressway in the
23 marked -- in the Malcolm X College campus. Is that
24 a viable option? I mean, this could be many years

1 away but --

2 MR. DANDORPH: It is certainly an option,
3 and it's in the planning phases right now in terms
4 of how we would use that land assuming that the
5 purchase of that land goes through from the City.
6 But that is part of the planning is that we would
7 relocate an academic village there, probably put the
8 university there, as well as student housing
9 adjacent to the university.

10 VICE CHAIRMAN HAYES: So you'd put a university
11 there and then have how many units of student housing?

12 MR. DANDORPH: I couldn't comment on that at
13 this point in time. We haven't gotten that far in
14 the planning phase.

15 VICE CHAIRMAN HAYES: And this is actually --
16 I read about this -- because the Chicago Blackhawks
17 want to put their practice facility on that land,
18 as well?

19 MR. DANDORPH: That's correct.

20 VICE CHAIRMAN HAYES: So about half that land
21 will be taken up by the Blackhawks' practice facility?

22 MR. DANDORPH: About a third of the land
23 will be purchased by the Blackhawks, and we'll
24 purchase the other two-thirds of that land, which

1 would be the footprint of what we would focus our
2 development efforts on.

3 VICE CHAIRMAN HAYES: Thank you.

4 CHAIRWOMAN OLSON: Any other questions or
5 comments?

6 I just want to clarify for the Board that
7 what we are voting on here is to approve the master
8 design project. This doesn't in any way obligate
9 the Board to approve anything further than that, but
10 that is exactly what we're going under today.

11 So seeing no other questions or comments, I
12 would ask for a roll call vote on Project 15-053,
13 Rush University Medical Center to approve their
14 master design project.

15 MR. ROATE: Thank you, Madam Chair. Motion
16 made by Mr. Hayes, seconded by Mr. Johnson --

17 MEMBER JOHNSON: No.

18 MR. ROATE: Was it Mr. Sewell? Who seconded
19 it? Did we get a second?

20 MEMBER BURZYNSKI: Second.

21 CHAIRWOMAN OLSON: Somebody, yes.

22 MR. ROATE: Senator Burzynski.

23 MEMBER BURZYNSKI: Yes, based on the findings.

24 MR. ROATE: Thank you, sir.

1 Senator Demuzio.

2 MEMBER DEMUZIO: Yes, based on staff report.

3 MR. ROATE: Thank you.

4 Justice Greiman.

5 MEMBER GREIMAN: Yes. But I wonder where
6 the students are going to be, and there are going to
7 be unhappy doctors.

8 MR. ROATE: Thank you.

9 Mr. Hayes.

10 VICE CHAIRMAN HAYES: Yes. Based on the
11 State agency report the applicant has addressed
12 13 criteria, and there was no negative findings, but
13 I also would like to -- you know, basically, we've
14 done a little bit of a valuation on the financial
15 and economically feasible. But, of course, I don't --
16 I mean, I do not have nearly the kind of information
17 right now to make a full analysis of that.

18 MR. ROATE: Thank you.

19 Mr. Johnson.

20 MEMBER JOHNSON: Yes, based on the State
21 agency report.

22 MR. ROATE: Thank you.

23 Mr. McGlasson.

24 MEMBER MCGLASSON: Yes, based on the State

1 agency report.

2 MR. ROATE: Mr. Sewell.

3 MEMBER SEWELL: Yes, for reasons stated.

4 MR. ROATE: Madam Chair.

5 CHAIRWOMAN OLSON: Yes, for reasons stated.

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

7 CHAIRWOMAN OLSON: The motion passes.

8 Congratulations and good luck.

9 MR. DANDORPH: Thank you.

10 CHAIRWOMAN OLSON: We'll be anxious to see
11 what you come up with. Next we have Project -- oh,
12 we will break for lunch until 12:35. That's
13 35 minutes from now.

14 We are adjourned until after lunch.

15 Thank you.

16 (Recess taken, 12:06 p.m. to 12:48 p.m.)

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CHAIRWOMAN OLSON: So with the Board's approval we're going to make another slight agenda alteration. We're going to actually allow Fresenius to come to the table now with their two projects, and then DaVita can come to the table with their four projects. All of these projects have no opposition and no findings.

So any issues with Board members doing it in that manner?

VICE CHAIRMAN HAYES: No.

CHAIRWOMAN OLSON: Okay. So we'll call to the table -- we're back in session, obviously.

We'll call to the table Project H-03, 15-046, Fresenius Medical Care Beverly Ridge in Chicago, and H-06, Project 15-050, Fresenius Medical Care Chicago Heights. Those two will come to the table now and be sworn in for the court reporter, please.

(Three witnesses sworn.)

CHAIRWOMAN OLSON: Okay. Mike, we'll start with H-03, Beverly Ridge, Chicago -- oh, I'm sorry.

MR. ROATE: We have no motion.

CHAIRWOMAN OLSON: Oh, I'm sorry.

1 May I have a motion to approve Project
2 15-046, Fresenius Medical Care Beverly Ridge to
3 establish a 16-station ESRD facility?

4 MEMBER JOHNSON: So moved.

5 MEMBER BURZYNSKI: Second.

6 CHAIRWOMAN OLSON: And you can swear in the
7 applicant.

8 THE COURT REPORTER: I did.

9 CHAIRWOMAN OLSON: You can't give me lunch.
10 Okay. Mr. Constantino, your report.

11 MR. CONSTANTINO: The applicants are
12 proposing to establish a 16-station ESRD facility in
13 approximately 9400 gross square feet of space -- of
14 leased space in Chicago, Illinois.

15 The cost of the project is approximately
16 \$5.4 million. The anticipated completion date is
17 June 30th, 2017. There were no findings, no public
18 hearing requested, no opposition comments received.

19 Thank you, Madam Chairwoman.

20 CHAIRWOMAN OLSON: Do you have comments for
21 the Board, or would you like to open it up for
22 questions?

23 MS. RANALLI: I just wanted to thank the
24 Board staff, and also wanted to thank Dr. Simpson

1 who is behind me who is the physician supporting
2 this project, and I'll leave it open for any
3 questions that you have.

4 CHAIRWOMAN OLSON: Questions from Board
5 members?

6 MEMBER GREIMAN: I have a question about the
7 industry.

8 On page 13, for example, there are 58 places
9 within close range of where you want to set this up.
10 51 of them are managed by DaVita and Fresenius,
11 51 out of 58.

12 So is there competition in prices for renal
13 operations, or are you all agreed to one on prices?
14 There's two major -- two major industries own
15 90 percent of the renal position. So is it
16 competition, or is it just the same?

17 Tell me if you want. You don't have to. I
18 mean, if guys are meeting in rooms and saying,
19 "Yeah, we're going to charge the same thing," you
20 don't have to tell me that but I'm just -- this
21 doesn't affect this deal. I'm just asking you about
22 the industry.

23 MS. RANALLI: The way the industry developed
24 there are two major players, and there is competition

1 among those two major players. But you're right,
2 Justice Greiman, those two companies, DaVita and
3 Fresenius, do for the most part, at least in the
4 area that you identified, control the majority of
5 dialysis services. But there are doctors and
6 physician-owned facilities peppered throughout
7 the state.

8 MEMBER GREIMAN: I understand that. But
9 90 percent are owned by these companies, you know.

10 MS. GURCHIEK: I also wanted to mention that
11 we work with a very large physician group that
12 practices predominantly on the south side of Chicago,
13 and that's the group that Dr. Simpson is part of.
14 And there's about 40 physicians in that practice, so
15 they have a very large presence in that south
16 Chicago market, which is one of the things that
17 drives the project.

18 MS. WRIGHT: Just one other thing.

19 ESRD is covered by Medicare, so no matter
20 what age the patient is, they can go on Medicare.
21 So that's going to be a flat rate no matter who the
22 provider is.

23 MEMBER GREIMAN: So prices are set by
24 Medicare?

1 THE COURT REPORTER: Okay. Can I have your
2 names --

3 MEMBER GREIMAN: I'm sorry if I disturbed
4 you in any way with that question.

5 THE COURT REPORTER: Can I have your names,
6 please?

7 MS. GURCHIEK: Sure. Teri Gurchiek,
8 G-u-r-c-h-i-e-k.

9 MS. WRIGHT: Lori Wright.

10 MS. RANALLI: Clare Ranalli.

11 CHAIRWOMAN OLSON: I have just one quick
12 question.

13 So this is leased space. Yet it still takes
14 a year and a half to do your build-out. Is that
15 about the average time of leased space to do the
16 build-outs?

17 MS. WRIGHT: The site is the currently
18 vacant land, and the developer is going to build a
19 building, and then we will lease it from him.

20 CHAIRWOMAN OLSON: I see.

21 Any other questions or comments from Board
22 members?

23 (No response.)

24 CHAIRWOMAN OLSON: Seeing none and I'll ask

1 for a roll call vote on Project 15-046, Fresenius
2 Medical Care Beverly Ridge to establish a 16-station
3 ESRD facility.

4 MR. ROATE: Thank you, Madam Chair.

5 Motion made by Mr. Johnson, seconded by
6 Senator Burzynski.

7 Senator Burzynski.

8 MEMBER BURZYNSKI: I vote yes based on the
9 summary of findings.

10 MR. ROATE: Thank you.

11 Senator Demuzio.

12 MEMBER DEMUZIO: Yes, based on staff findings.

13 MR. ROATE: Thank you.

14 Justice Greiman.

15 MEMBER GREIMAN: Yes, based on the findings,
16 as well.

17 MR. ROATE: Thank you.

18 Mr. Hayes.

19 VICE CHAIRMAN HAYES: Yes, based on the
20 State agency report, favorable State agency report.

21 MR. ROATE: Thank you.

22 Mr. Johnson.

23 MEMBER JOHNSON: Yes, based on staff
24 findings.

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MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MCGLASSON: Yes, based on summary
findings.

MR. ROATE: Mr. Sewell.

MEMBER SEWELL: Yes, for reasons stated.

MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: Yes, for reasons stated,
as well.

MR. ROATE: 8 votes in the affirmative.

CHAIRWOMAN OLSON: The motion passes.

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CHAIRWOMAN OLSON: Now we'll jump right into Project H-06, 15-050, Fresenius Medical Care Chicago Heights to establish a 12-station ESRD facility.

May I have a motion?

MEMBER SEWELL: So moved.

CHAIRWOMAN OLSON: And a second.

VICE CHAIRMAN HAYES: Second.

CHAIRWOMAN OLSON: Mr. Constantino.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The applicants are proposing to establish a 12-station ESRD facility in approximately 9600 gross square feet of leased space at a cost of approximately \$6.3 million. The anticipated completion date is December 31st, 2017. There were no findings, no opposition, and no public hearing had been requested.

Thank you, Madam Chairwoman.

CHAIRWOMAN OLSON: Questions or comments from Board members.

(No response.)

CHAIRWOMAN OLSON: So I have just one, and it's kind of like the last one. So now this one is new construction but not leased, but it's going to take six months longer. So why does -- I'm just

1 curious.

2 MS. WRIGHT: This one is vacant land that is
3 going to have a building built on it, but this one
4 is currently just a big parking lot, and there's a
5 lot of different grades, and there's going to be a
6 lot of extra work that has to be done to bring it up
7 to street level.

8 CHAIRWOMAN OLSON: So site work?

9 MS. WRIGHT: Site work, yeah.

10 CHAIRWOMAN OLSON: Just curious.

11 Any other questions?

12 Mr. Hayes.

13 VICE CHAIRMAN HAYES: You know, this is kind
14 of along the same lines. On Table 1 on page 4 of
15 14 here you have the current Fresenius projects, and
16 I think even DaVita probably has -- I think they do
17 have a little bit of the same.

18 But, you know, there's an awful lot of
19 projects coming on board. You know, you have FMC Zion
20 which won't be completed until June of 2017. So, you
21 know, a lot of these are -- it takes a long time it
22 sounds like for these projects to come to fruition.

23 MS. WRIGHT: It's usually about 18 months,
24 and then lot of times we're held up waiting for the

1 certification for Medicare. Sometimes we wait
2 several months for them to come out and inspect. If
3 there's any deficiencies, anything that needs to be
4 corrected, that adds additional time, and then we
5 don't close out our project here with the Board
6 until we've received a letter, and that can take an
7 additional three months. So there's probably a
8 seven-month period of just getting certification on
9 top of the construction.

10 VICE CHAIRMAN HAYES: Now, with the need in
11 an area -- which this does have. The calculated
12 need is how much?

13 MR. CONSTANTINO: 69 stations.

14 VICE CHAIRMAN HAYES: Okay. That's after
15 the one we just approved; is that right?

16 MR. CONSTANTINO: No, you haven't approved
17 this one. This is in HSA 7.

18 VICE CHAIRMAN HAYES: It's in a different
19 HSA. Okay.

20 Now, is it just -- it sounds like a lot of
21 times, with a need a lot of these projects are kind
22 of pushed forward, in my opinion, to be able to get
23 them in as soon as possible. So, you know, you can
24 spend 18 months, 2 years, 2 1/2 years on -- to be

1 able to complete these projects.

2 MS. WRIGHT: That is true. However, ideally
3 we would like these clinics to open up as quickly as
4 possible. Usually, we've got other clinics in the
5 area that are just busting at the seams with
6 patients; we don't have anyplace else to put them,
7 and we want to alleviate those clinics as soon as
8 possible.

9 Also, we have construction schedules with a
10 company that we try to meet. We want to get done
11 sooner, it's just by the time we do permitting and
12 depending on the time of year it's approved, we'd
13 have to wait through the winter before we begin
14 construction. Sometimes there's hiccups along the
15 way that we weren't expecting, and then the
16 certification process. But we would like to get
17 them up and running as quickly as possible.

18 VICE CHAIRMAN HAYES: Okay. Thank you.

19 CHAIRWOMAN OLSON: Other questions or comments
20 from Board members?

21 (No response.)

22 CHAIRWOMAN OLSON: Seeing none, I'll ask for
23 a roll call vote on Project 15-0 50, Fresenius Medical
24 Care Chicago Heights to establish a 12-station ESRD

1 facility.

2 MR. ROATE: Thank you, Madam Chair. Motion
3 made by Mr. Sewell, seconded by Mr. Hayes.

4 Senator Burzynski.

5 MEMBER BURZYNSKI: Vote yes based on the
6 findings.

7 MR. ROATE: Senator Demuzio.

8 MEMBER DEMUZIO: Yes, based on staff
9 findings.

10 MR. ROATE: Thank you.

11 Justice Greiman.

12 MEMBER GREIMAN: Yes. I'll base mine on the
13 same thing.

14 MR. ROATE: Thank you.

15 Mr. Hayes.

16 VICE CHAIRMAN HAYES: Yes, based on the
17 findings of the State agency report.

18 MR. ROATE: Thank you.

19 Mr. Johnson.

20 MEMBER JOHNSON: Yes, for previously
21 mentioned reasons.

22 MR. ROATE: Thank you.

23 Mr. McGlasson.

24 MEMBER MCGLASSON: Yes, based on staff

1 findings.

2 MR. ROATE: Thank you.

3 Mr. Sewell.

4 MEMBER SEWELL: Yes. Based on State agency
5 report.

6 MR. ROATE: Thank you.

7 Madam Chair.

8 CHAIRWOMAN OLSON: Yes, for reasons stated.

9 MR. ROATE: Thank you.

10 That's 8 votes in the affirmative.

11 CHAIRWOMAN OLSON: Motion passes.

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CHAIRWOMAN OLSON: Now I'll call to the table DaVita for Projects H-04, H-05, H-07, and H-08. Is that acceptable to you?

MS. DAVIS: That would be great. Thank you.

CHAIRWOMAN OLSON: First, we'll hear H-04, DaVita Park Manor Dialysis.

May I have a motion to approve Project 15-048, DaVita Park Manor Dialysis to establish a 16-station ESRD facility?

VICE CHAIRMAN HAYES: So moved.

MEMBER SEWELL: Second.

CHAIRWOMAN OLSON: Okay. If you'll introduce yourselves and be sworn in, please.

MR. SHEETS: Charles Sheets from Polsinelli on behalf of the applicants.

MS. DAVIS: Penny Davis, division vice president, DaVita.

DR. ARORA: Dr. Amit Arora, Nephrology Associates of Northern Illinois.

MR. DANIELI: Yoni Danieli, regional director, DaVita.

MS. COOPER: Anne Cooper, counsel for the applicants.

1 (Five witnesses sworn.)

2 CHAIRWOMAN OLSON: Mr. Constantino, your
3 report, please.

4 MR. CONSTANTINO: Thank you, Madam Chairwoman.

5 The applicants are proposing to establish a
6 16-station ESRD facility in approximately 7,770 gross
7 square feet of space in Chicago, Illinois, at a cost
8 of approximately \$4.1 million. The anticipated
9 completion date is February 28th, 2018. There were
10 no findings, no public hearing, and no opposition
11 letters received.

12 Thank you, Madam Chairwoman.

13 CHAIRWOMAN OLSON: Thank you, Mike.

14 Would you like to open it to questions or do
15 you have comments?

16 MS. DAVIS: I just have a few comments I'd
17 like to make.

18 CHAIRWOMAN OLSON: Sure.

19 MS. DAVIS: And this relates to all of the
20 DaVita projects. I'd like to thank the Board and
21 the staff for all their efforts and for our wholly
22 positive reports.

23 DaVita is committed to quality of care for
24 our patients as evidenced by the most recent CMS

1 5-star ratings in the quality incentive program.
2 Based on publicly reported data, 54 percent of
3 DaVita's facilities in Illinois were ranked at 4 out
4 of 5 stars, as opposed to other providers in the
5 state where only 15 percent of their facilities were
6 ranked a 4 out of 5 stars.

7 There's significant evidence that patients
8 treated in 4- and 5-star facilities have a reduction
9 in overall cost to the health care system by fewer
10 hospitalizations and infections. DaVita's average
11 QIP score, quality incentive program score was
12 87.9 with our nearest competitor at 73.

13 We're often asked about market share. And
14 based on the December 31, 2014, date, the most
15 recent ESRD data, DaVita's market share in the
16 Chicagoland area, which is HSA 6, 7, 8 and 9, was at
17 22.9 percent. FMC's market share was 56 percent.
18 And this is Chicago and the surrounding counties.
19 Based on our internal data through 12/31/15, our
20 market share is still at 25 percent and FMC at
21 60 percent.

22 We want to thank you so much for your
23 consideration of all the projects today, and I'd be
24 happy to take any questions.

1 CHAIRWOMAN OLSON: Thank you.

2 Questions or comments from Board members?

3 (No response.)

4 CHAIRWOMAN OLSON: So this is new construction
5 and you're anticipating two years?

6 MS. DAVIS: Right.

7 CHAIRWOMAN OLSON: Seeing no further -- oh,
8 I'm sorry -- John.

9 VICE CHAIRMAN HAYES: Yes, please.

10 I was wondering if you could explain the
11 ownership here. It says here Total Renal Care owns
12 75 percent. And that's DaVita?

13 MS. DAVIS: Right.

14 VICE CHAIRMAN HAYES: Then Pollier Dialysis,
15 LLC, and the University of Chicago Medical Center
16 owns 25 percent?

17 MS. DAVIS: That's correct. We've decided
18 that on this project in this community in Park Manor
19 that it makes sense to partner with the academic
20 medical center in the community.

21 Their physicians currently serve as medical
22 directors at three of our in-center units and our
23 home program on the south side, and so they're our
24 partner in this project. They will be the medical

1 director in this project, and we believe the
2 commitment to clinical research that we do with the
3 University of Chicago will enhance the project.

4 VICE CHAIRMAN HAYES: Okay. Thank you.

5 CHAIRWOMAN OLSON: Other questions or
6 comments?

7 (No response.)

8 CHAIRWOMAN OLSON: Seeing none, I'll ask for
9 a roll call vote on Project H-04, DaVita Park Manor
10 Dialysis Chicago.

11 MR. ROATE: Thank you, Madam Chair. Motion
12 made by Mr. Hayes, seconded by Mr. Sewell.

13 Senator Burzynski.

14 MEMBER BURZYNSKI: Yes, based on the summary
15 of findings.

16 MR. ROATE: Thank you.

17 Senator Demuzio.

18 MEMBER DEMUZIO: Yes, based on staff report.

19 MR. ROATE: Thank you.

20 Justice Greiman.

21 MEMBER GREIMAN: Yes, based on the staff
22 report.

23 MR. ROATE: Thank you.

24 Mr. Hayes.

1 VICE CHAIRMAN HAYES: Yes, based on the
2 State agency report.

3 MR. ROATE: Thank you.
4 Mr. Johnson.

5 MEMBER JOHNSON: Yes, based on the State
6 agency report.

7 MR. ROATE: Mr. McGlasson.

8 MEMBER MCGLASSON: Yes, based on the summary
9 of findings.

10 MR. ROATE: Thank you.

11 Mr. Sewell.

12 MEMBER SEWELL: Yes, based on the State
13 agency report.

14 MR. ROATE: Madam Chair.

15 CHAIRWOMAN OLSON: Yes, based on the
16 positive State Board staff report.

17 MR. ROATE: 8 votes in the affirmative.

18 CHAIRWOMAN OLSON: The motion passes.
19 Congratulations.

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CHAIRWOMAN OLSON: We'll move right into Project H-0, 15-049, DaVita Huntley Dialysis in Huntley.

May I have a motion to approve Project 15-049, DaVita Huntley Dialysis to establish a 12-station ESRD facility?

MEMBER BURZYNSKI: So moved.

CHAIRWOMAN OLSON: May I have a second, please?

MEMBER JOHNSON: Second.

CHAIRWOMAN OLSON: Thank you.

Mr. Constantino, your report.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The applicants are proposing to establish a 12-station ESRD facility in approximately 8700 gross square feet of space in Huntley, Illinois, at an approximately \$3.3 million. The anticipated project completion date is February 28th, 2018. There were no findings, no public hearing, and no opposition to this project.

Thank you, Madam Chairwoman.

CHAIRWOMAN OLSON: Any further comments for the Board?

1 MS. DAVIS: No. I'll take any questions.

2 CHAIRWOMAN OLSON: Questions, comments from
3 Board members?

4 (No response.)

5 CHAIRWOMAN OLSON: Seeing none, I'll ask for
6 a roll call vote on 15-049, DaVita Huntley Dialysis.

7 MR. ROATE: Thank you, Madam Chair. The
8 motion was made by again -- I'm sorry.

9 MEMBER BURZYNSKI: Me.

10 MR. ROATE: Seconded by?

11 CHAIRWOMAN OLSON: Johnson.

12 MR. ROATE: Motion made by Senator Burzynski,
13 seconded by Mr. Johnson.

14 Senator Burzynski.

15 MEMBER BURZYNSKI: Yes, based on staff report.

16 MR. ROATE: Senator Demuzio.

17 MEMBER DEMUZIO: Yes, based on staff report.

18 MR. ROATE: Justice Greiman.

19 MEMBER GREIMAN: Based on the staff report,
20 I vote aye.

21 MR. ROATE: Thank you.

22 Mr. Hayes.

23 VICE CHAIRMAN HAYES: Yes, based on the
24 findings of the State agency report.

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MR. ROATE: Mr. Johnson.

MEMBER JOHNSON: Yes, for previously stated reasons.

MR. ROATE: Mr. McGlasson.

MEMBER MCGLASSON: Yes, based on staff report.

MR. ROATE: Mr. Sewell.

MEMBER SEWELL: Yes, based on State agency report.

MR. ROATE: Madam Chair.

CHAIRWOMAN OLSON: Yes, for reasons stated.

MR. ROATE: 8 votes in the affirmative.

CHAIRWOMAN OLSON: The motion passes.

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CHAIRWOMAN OLSON: Next we'll move to H-07, Project 15-052, DaVita Sauget Dialysis. This is for the establishment of a 16-station -- add 8 stations to an existing 16-station ESRD.

May I have a motion?

VICE CHAIRMAN HAYES: So moved.

CHAIRWOMAN OLSON: And a second, please.

MEMBER BURZYNSKI: Second.

CHAIRWOMAN OLSON: Okay. Mr. Constantino, your report.

MR. CONSTANTINO: The applicants are proposing to add 8 dialysis stations to an existing 16-station dialysis facility in Sauget, Illinois, at a cost of approximately \$1.5 million. The anticipated completion date is August 31st, 2017. There was no opposition, no public hearing requested, and no findings.

Thank you, Madam Chairwoman.

CHAIRWOMAN OLSON: Questions for Board members?

VICE CHAIRMAN HAYES: You know, I wanted to, again, discuss with DaVita here your -- you know, basically your outstanding projects, and that's on

1 page 4 of 11 in the State agency report.

2 You know, again, there's quite a few of
3 them, and they go -- now, they really don't have --
4 a lot of them open in 2017, and I was wondering if
5 you could comment on that. Especially sometimes
6 when you start coming before the Board, you know, it
7 sounds like if there's a need or a change here that
8 a lot of times these projects may not be completed
9 as quickly as they should be, you know. And, of
10 course, you have the -- if you get a permit, you
11 know, that's what you want to do at the beginning,
12 to get this permit, and then, you know, you probably
13 take a little bit more time to complete them.

14 MS. DAVIS: Our goal is not to have to go
15 beyond the permit period. The only time that we do
16 is generally if it's been slow to get surveyors out.

17 For the projects on here, Chicago Ridge
18 actually treated their first patient in November,
19 and we're just waiting for surveyors. Tinley Park
20 will actually treat its first patient in May, and
21 it's our goal to get the surveyors out by October.
22 Stoney Creek relocated the first week of January, so
23 they've met that date; we should be sending in a
24 cost report shortly.

1 I can't speak to Machesney Park, Vermillion
2 or Alton because those are not my division.

3 The Calumet City, that is on target. We
4 expect to have first treatment by December of this
5 year, 2016, and be certified well before that 2017
6 date. South Holland, same thing; we expect the
7 first treatment to be January 2017 and with survey
8 time of three to four months be well before the
9 permit date. Morris Dialysis, that facility could
10 be up and running as early as July of '16. Lincoln
11 Park is on target for a November 1st of '16
12 treatment, and that will give us enough time for
13 survey. And Montgomery I'm not aware of; it's not
14 my area.

15 So hopefully that helps that we really do
16 try to make sure that we -- and that we're not
17 duplicating in terms of building a center even
18 though there's another center that's already being
19 built. So I don't come here as often -- and as you
20 can see by our market share at 23 percent, we really
21 don't -- we're not going to duplicate and take
22 patients from our own existing centers or planned
23 existing centers.

24 VICE CHAIRMAN HAYES: A lot of these

1 projects -- now, when you mentioned that you're
2 treating a patient, Medicare, which is your main
3 source of a payor, they allow you to do that before
4 you're certified by CMS and then IDPH; is that right?

5 MS. DAVIS: No. Actually, until we're
6 certified we can only take one commercial patient,
7 one patient who is insured by a payor that allows
8 the patient to treat in network with us even before
9 they become certified because of DaVita's reputation
10 and our contracts with those payers.

11 So, for instance, Aetna and Cigna will allow
12 a patient to treat in an uncertified facility until we
13 get Medicare certification, and they do reimburse us.
14 We cannot take Medicare or Medicaid patients until
15 we get our CMS certification as, number one, there's
16 no reimbursement, but, number two, they frown on that.

17 VICE CHAIRMAN HAYES: Okay. Thank you.

18 CHAIRWOMAN OLSON: And so you have the space
19 currently in this building that you're going to add
20 these eight stations?

21 MS. DAVIS: Yes.

22 MEMBER MCGLASSON: I'd like to ask a question.

23 CHAIRWOMAN OLSON: Yes, please.

24 MEMBER MCGLASSON: As a basis of my question,

1 I've noticed quite a disparity in all of the centers
2 the square footage per station. This seems quite
3 small in comparison to the others.

4 MS. DAVIS: I would ask Yoni to address that.

5 MR. DANIELI: There is enough space in the
6 existing to accommodate adding eight additional
7 stations.

8 MS. DAVIS: It's smaller because of the fact
9 that you don't have the extra factor of more space
10 for social worker, dieticians, water treatment space.
11 That's already in the existing facility. So all
12 you're actually adding is the space for the stations
13 versus all of the support staff.

14 CHAIRWOMAN OLSON: Any other questions or
15 comments?

16 (No response.)

17 CHAIRWOMAN OLSON: Do you have an event
18 planner for all these open houses?

19 Seeing none, I'll call for a roll call vote
20 on Project 15-052, DaVita Sauget Dialysis to add
21 eight stations to an existing facility.

22 MR. ROATE: Thank you, Madam Chair. Motion
23 made by Mr. Hayes, seconded by Senator Burzynski.

24 Senator Burzynski.

1 MEMBER BURZYNSKI: Vote yes based on the
2 State board staff report.

3 MR. ROATE: Senator Demuzio.

4 MEMBER DEMUZIO: Yes, based on staff report.

5 MR. ROATE: Justice Greiman.

6 MEMBER GREIMAN: I vote yes based on the
7 statement of facts by the agency.

8 MR. ROATE: Mr. Hayes.

9 VICE CHAIRMAN HAYES: Yes, based on the
10 State agency report.

11 MR. ROATE: Thank you.

12 Mr. Johnson.

13 MEMBER JOHNSON: Yes, based on the staff
14 report.

15 MR. ROATE: Mr. McGlasson.

16 MEMBER MCGLASSON: Yes, based on the staff
17 report.

18 MR. ROATE: Mr. Sewell.

19 MEMBER SEWELL: Yes, based on the State
20 agency report.

21 MR. ROATE: Madam Chair.

22 CHAIRWOMAN OLSON: Yes, for reasons stated.

23 MR. ROATE: 8 votes in the affirmative.

24 CHAIRWOMAN OLSON: The motion passes.

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CHAIRWOMAN OLSON: And then we'll move finally to H-08, Project 15-054, DaVita Washington Heights Dialysis to establish a 16-station ESRD facility.

Mr. Constantino, your report.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The applicants are proposing to establish a 16-station ESRD facility in approximately 7,500 gross square feet of leased space at a cost of approximately \$3.9 million. The anticipated project completion date is September 30th, 2017. There are no findings; there's no opposition, and no public hearing was requested.

Thank you, Madam Chairwoman.

CHAIRWOMAN OLSON: Questions or comments from Board members?

(No response.)

CHAIRWOMAN OLSON: I have a question because I didn't do the math. I'm sorry.

This is the third project in HSA 6; is that correct? So at the end of the day, if all three are approved, where will we be with the need?

1 MR. CONSTANTINO: Right now there's a need for
2 104 stations. You're going to eliminate 48 stations
3 from that if you approve this project.

4 CHAIRWOMAN OLSON: Thank you.

5 Other questions or comments?

6 (No response.)

7 CHAIRWOMAN OLSON: Seeing none, I'll ask for
8 a roll call vote on 15-045, DaVita Washington Heights
9 Dialysis.

10 MR. ROATE: Senator Burzynski.

11 MEMBER BURZYNSKI: Yes, based on the State
12 Board staff report.

13 MR. ROATE: Senator Demuzio.

14 MEMBER DEMUZIO: Yes, based on the staff
15 report.

16 MR. ROATE: Justice Greiman.

17 MEMBER GREIMAN: Yes, based on the staff
18 report.

19 MR. ROATE: Mr. Hayes.

20 VICE CHAIRMAN HAYES: Yes, based on the
21 favorable State agency report.

22 MR. ROATE: Mr. Johnson.

23 MEMBER JOHNSON: Yes, for previously stated
24 reasons.

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MR. ROATE: Mr. McGlasson.

MEMBER MCGLASSON: Yes, based on staff reports.

MR. ROATE: Mr. Sewell.

MEMBER SEWELL: Yes, based on the State agency report.

MR. ROATE: Madam Chair.

CHAIRWOMAN OLSON: I'm sorry. Yes, based on the positive Board staff report.

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

CHAIRWOMAN OLSON: The motion passes.
Thank you.

MS. DAVIS: Thank you so much.

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CHAIRWOMAN OLSON: Next we have H-10,
Project 15-058, OSF St. Elizabeth freestanding
emergency center in Streator.

May I have a motion to approve Project 15-058,
OSF St. Elizabeth to establish a freestanding
emergency center in Streator?

MEMBER BURZYNSKI: So moved.

MEMBER SEWELL: Second.

CHAIRWOMAN OLSON: Would you please introduce
yourselves and be sworn in.

DR. GORENZ: Dr. David Gorenz.

MS. RANALLI: Clare Ranalli.

DR. YEH: Dr. Leon Yeh.

MS. BRENNAN: Megan Brennan.

MR. BUETKE: Ken Buetke.

(Five witnesses sworn.)

CHAIRWOMAN OLSON: Mr. Constantino, your
report, please.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The applicants are proposing establishment of
a freestanding emergency center to be located at the
discontinued St. Mary's Hospital in Streator. The
cost of the project is approximately \$1.1 million, and

1 the anticipated completion date is June 30th, 2016.
2 There were no findings, no opposition, and no public
3 hearing was requested.

4 Thank you, Madam Chairwoman.

5 CHAIRWOMAN OLSON: Before I turn it over to
6 the applicant, I'm going to ask that Juan explain to
7 the Board the legislation involved with this project.

8 MR. MORADO: This Board at a previous
9 meeting had approved a certificate of exemption for
10 discontinuation of the St. Mary's facility.

11 Subsequent to that, legislation was
12 introduced in the General Assembly and was passed
13 both through the House and Senate and signed by
14 Governor Rauner which would allow for the
15 establishment of a freestanding emergency center in
16 Streator, Illinois.

17 The legislation merely allowed the applicant
18 to apply to establish an FEC in that area. This
19 Board is under no obligation to, in fact, grant this
20 certificate of need solely because of that
21 legislation being passed. The legislation merely
22 created the opportunity for them to come before
23 you today.

24 CHAIRWOMAN OLSON: And if I'm correct, the

1 legislation was specific to this project in Streator.

2 MR. MORADO: It was written in a way that it
3 is specific to the Streator community, correct.

4 CHAIRWOMAN OLSON: Other questions?

5 (No response.)

6 CHAIRWOMAN OLSON: Seeing none, is the
7 applicant -- please, go ahead.

8 DR. GORENZ: My name is Dr. David Gorenz.
9 I'm the regional CEO for OSF Healthcare. I'd like
10 to introduce Clare Ranalli, our CON counsel;
11 Dr. Leon Yeh, who is the vice president for
12 emergency services and the medical director for OSF
13 Healthcare for emergency services; Megan Brennan,
14 who is the director of the emergency department at
15 OSF St. Elizabeth Hospital; and Ken Buetke, the
16 president of OSF St. Elizabeth Medical Center.

17 MEMBER GREIMAN: Please speak into the mic.

18 DR. GORENZ: We are here today on behalf of
19 OSF St. Elizabeth requesting establishment of a
20 freestanding emergency center in Streator, Illinois.
21 It will be located in the site of the previously
22 St. Mary's Hospital that was closed on January 4th of
23 this year.

24 We appreciate the timely manner that this

1 has been dealt with by not only the staff but this
2 Board in hearing our application for a freestanding
3 emergency center. As we have met all the review
4 criteria, we will forego a formal presentation but
5 be glad to answer any questions that you may have.

6 CHAIRWOMAN OLSON: Thank you.

7 Questions from Board members.

8 MEMBER MCGLASSON: If I may.

9 I think I understand correctly that hospitals
10 are obligated to provide a certain amount of
11 community benefit and charity care. I notice that
12 the name of St. Mary's in Streator has gone by the
13 wayside. Will you be offering these services of
14 charity care and the benefits to Streator residents
15 or entirely attached to --

16 DR. GORENZ: We will see all patients that
17 come to us and certainly abide by -- turn no one
18 away for the care that's needed.

19 MEMBER MCGLASSON: And community benefit, also?

20 DR. GORENZ: Yes.

21 CHAIRWOMAN OLSON: Other questions or
22 comments?

23 MEMBER BURZYNSKI: Madam Chair, I just had
24 one question because this one did involve

1 legislative activity, and I did attend the public
2 hearing in Streator, as well.

3 My question is very simple. Was it your
4 intent to establish the freestanding emergency room
5 prior to the passage of the legislation?

6 DR. GORENZ: Well, we requested and worked
7 with the local legislators to have that legislation
8 crafted. I think very early on when it was announced
9 that St. Mary's Hospital was going to close it
10 became evident that one of the bigger concerns of
11 the community -- they certainly had concerns about
12 the hospital closing, but a very large concern had
13 to do with emergency services.

14 So it became obvious to us to meet the
15 community needs that if we could establish a
16 freestanding emergency center we could sort of
17 mitigate many of their concerns about the closure of
18 the hospital.

19 MEMBER BURZYNSKI: Okay. Thank you.

20 I think that's a good piece of advice that we
21 might be able to give everyone who works on a
22 certificate of need in the future. Had this been
23 applied for prior to, it is my understanding we
24 wouldn't be here today -- or we wouldn't need to have

1 special legislation, let me put it that way. We
2 wouldn't have had to have the special legislation --
3 you're going to correct me.

4 MR. MORADO: I'm not correcting you but
5 would just make a comment.

6 MEMBER BURZYNSKI: I'll take correction.

7 MR. MORADO: The way that the law is written
8 with regards to freestanding emergency centers,
9 they're limited. So, in fact, in order for there to
10 be an application, it had to go through legislative
11 process.

12 MEMBER BURZYNSKI: I stand corrected. Thank
13 you.

14 CHAIRWOMAN OLSON: So can you explain your
15 approval from IDPH with regard to ambulance transfers?
16 Because I believe that's been completed, as well.

17 DR. GORENZ: Let me ask Dr. Yeh.

18 CHAIRWOMAN OLSON: Please, Doctor.

19 DR. YEH: I'd be happy to answer that.

20 IDPH has granted us a waiver for BLS traffic
21 at this point while it is used as an urgent care.
22 So this allows lower acuity patients while pending
23 your review and permit for a freestanding emergency
24 center.

1 CHAIRWOMAN OLSON: But your intention is
2 still to open in four months?

3 DR. YEH: Once we're permitted to accept ALS
4 traffic, we will ask IDPH for that permission. So
5 once we have the license and permit for the
6 emergency care center, we will ask IDPH for that
7 permission to bring ALS traffic there, as well. So
8 we would see all manner of emergencies.

9 CHAIRWOMAN OLSON: So, Bill, can you answer
10 for me, is that a process -- I'm amazed that you got
11 this legislation through as fast as you did. I
12 guess it speaks to the critical need for this
13 project. But how long -- could we hope that IDPH
14 won't hold them up on trying to get this thing going?

15 MR. DART: Well, briefly, I would just say
16 the Department has been working with the group to
17 let them take the basic life support patients, and
18 moving ahead I'm sure that we'll try and expedite
19 this as much as possible given the regulations. We
20 want to be assured that all the regulations and
21 protections are there, but by all means, we've been
22 available and will continue to be.

23 MS. RANALLI: Right. And, Madam Chair, the
24 application for licensure has been submitted, and

1 IDPH has worked with us to make sure that it is T'd
2 up. So if you approve this here today, the
3 licensure application is pretty much ready to go and
4 hopefully will be approved. In contemplation of
5 hopefully your approval, we made sure we submitted
6 it early, and OSF has been working diligently with
7 IDPH so we can get going as quickly as possible.

8 CHAIRWOMAN OLSON: So now if I am an ALS
9 patient in Streator, when the ambulance comes, they
10 need to take me 18 miles to Ottawa?

11 DR. YEH: Correct.

12 CHAIRWOMAN OLSON: I just want to make sure
13 I understood that.

14 Well, again, it puts faith back in government
15 that we can get things done, and I hope it will
16 continue on that process because I know there was
17 certainly a lot of emotion surrounding this issue at
18 our last meeting, and I'm pleased that you're here
19 to try to help address the concerns of the community
20 of Streator. As somebody from a small rural
21 community, I certainly understand their concerns.

22 Questions or comments?

23 MEMBER GOYAL: Madam Chair, if I may.

24 CHAIRWOMAN OLSON: Yes.

1 MEMBER GOYAL: Some years ago there were
2 some situations reported where urgent care centers
3 got in trouble for not having the backup that
4 patients needed, and it was not predetermined in the
5 field, in the example that our Chair just gave,
6 where somebody knew that they'll need more care than
7 is available at that facility.

8 Could you help explain that situation a
9 little bit? Because what do not seem to be life-
10 threatening emergencies could become emergencies
11 very quickly. And one example would be a normal
12 labor that develops into a complicated labor.

13 So how does that work out when you don't
14 have all the hospital supports, people are coming in
15 because of the word "Emergency" and -- just help me
16 understand.

17 DR. YEH: That's a good question. We've
18 worked -- in our work with IDPH which was extremely
19 collaborative, our EMS medical directors have put
20 together protocols to be used in a prehospital
21 setting which they vetted and also approved for use
22 in the BLS transports to the facility currently and
23 will work continuously for the ALS transport
24 protocols, as well.

1 The current state, even operating as an
2 urgent care, we have fully board-certified emergency
3 physicians and staff working in that facility. In
4 fact, we retained staff who was previously working
5 at St. Mary and continue to contract with the same
6 group of board-certified emergency physicians who
7 were there previously in order to maintain the
8 functionality of services of a full-fledged
9 emergency department despite it being called an
10 urgent care.

11 So at this point in time, we have every
12 confidence that we can provide critical acute care
13 that's needed if anyone should arrive at the
14 doorstep in a full-capacity emergency room setting.

15 MEMBER GOYAL: Would there be any type of
16 reporting then either to IDPH or maybe back to this
17 Board in a couple years?

18 DR. YEH: Yes. In fact, there's work being
19 done right now to compile quality data, transport
20 numbers and metrics and outcomes. This was one of
21 the provisions IDPH had set up for us, also, to give
22 quarterly reports. And in working with our partner
23 in prehospital transports, that was another quality
24 measure we were going to look at, as well, is

1 collect this data for a study on the appropriateness
2 of care and safety of bringing patients to this
3 facility.

4 MEMBER GOYAL: Thank you.

5 CHAIRWOMAN OLSON: I think that was a great
6 question because I do think that that's something
7 that this Board would be very interested in, as
8 well. While we understand there was legislation
9 introduced for this particular facility, my
10 understanding is it would be the only one of its
11 kind in the State of Illinois. And in the future if
12 there is other legislation that duplicates this kind
13 of a model, I think that that kind of information
14 could be very valuable to the Board, your outcomes,
15 successes as well as difficulties that you run into.
16 I think it would be incredible information for us to
17 have in the event that another project like this
18 were to come before us.

19 DR. GORENZ: Thank you. I'd just like to
20 mention, too, in the event a patient does need to be
21 transferred from the freestanding emergency center,
22 we have an ambulance that's actually stationed at
23 the freestanding emergency center. In addition, we
24 have a heliport. We operate our own flight program

1 so that we actually have a helicopter stationed
2 about 10 to 15 miles away from Streator. So we have
3 those to ensure that if a patient does need to be
4 transported to a higher level of care, we can do
5 that in a very timely manner.

6 CHAIRWOMAN OLSON: Thank you.

7 Other questions or comments from Board
8 members?

9 (No response.)

10 CHAIRWOMAN OLSON: Seeing none, I'd ask for a
11 roll call vote on Project 15-058, OSF St. Elizabeth
12 freestanding emergency center in Streator.

13 MR. ROATE: Thank you, Madam Chair. Motion
14 made by Senator Burzynski, seconded by Mr. Sewell.

15 Senator Burzynski.

16 MEMBER BURZYNSKI: I'm pleased to vote yes
17 based on the staff report and the need in the
18 community.

19 MR. ROATE: Thank you.

20 Senator Demuzio.

21 MEMBER DEMUZIO: Yes, based on the staff
22 report.

23 MR. ROATE: Thank you.

24 Justice Greiman.

1 MEMBER GREIMAN: Also on the staff report I
2 vote aye.

3 MR. ROATE: Thank you.
4 Mr. Hayes.

5 VICE CHAIRMAN HAYES: Yes, based on the
6 favorable State agency report.

7 MR. ROATE: Mr. Johnson.

8 MEMBER JOHNSON: Yes, based on the State
9 agency report.

10 MR. ROATE: Mr. McGlasson.

11 MEMBER MCGLASSON: Yes, based on staff report.

12 MR. ROATE: Mr. Sewell.

13 MEMBER SEWELL: Yes, no negative findings by
14 the staff.

15 MR. ROATE: Madam Chair.

16 CHAIRWOMAN OLSON: Yes, for reasons stated
17 and for the benefit of the community of Streator.

18 MR. ROATE: 8 votes in the affirmative.

19 CHAIRWOMAN OLSON: The motion passes.
20 Good luck.

21 We're going to take a 10-minute break and
22 we'll be right back.

23 (Recess taken, 1:33 p.m. to 1:42 p.m.)
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CHAIRWOMAN OLSON: Call the meeting back
to order.

Next we have Project H-11, 15-044,
Transformative Health of McHenry.

May I have a motion to approve Project 15-044,
Transformative Health of McHenry to establish a
98-bed long-term care facility in McHenry.

A motion and a second.

THE COURT REPORTER: I couldn't tell who was
doing it, though.

CHAIRWOMAN OLSON: When you make your motion
or your second, can you raise your -- you firsted
and John.

THE COURT REPORTER: Who firsted?

CHAIRWOMAN OLSON: Senator Demuzio.

THE COURT REPORTER: Thank you.

CHAIRWOMAN OLSON: And John Hayes seconded.

THE COURT REPORTER: Thank you.

CHAIRWOMAN OLSON: And if you could be sworn
in, please.

(Three witnesses sworn.)

CHAIRWOMAN OLSON: Mr. Constantino, your
report.

1 MR. CONSTANTINO: I'd first like to mention
2 we passed out comments to the Board report. You
3 have them in front of you. They were also e-mailed
4 to you the first of last week.

5 MR. MORADO: They were timely?

6 MR. CONSTANTINO: Both were timely. There's
7 two comment letters there.

8 CHAIRWOMAN OLSON: Thank you. I'll give the
9 Board just a minute to look over those records in
10 case they didn't read their e-mail, their State
11 e-mail.

12 Mr. Constantino, can I have your report,
13 please?

14 MR. CONSTANTINO: The applicants are proposing
15 to construct and operate a 98-bed long-term care
16 facility on the campus of Centegra Hospital in
17 McHenry. The anticipated cost of the project is
18 approximately \$19.2 million. The anticipated
19 completion date is December 31st, 2017. There was
20 no public hearing. There was opposition and support
21 letters received by the State Board staff, and there
22 were findings regarding this project.

23 Thank you, Madam Chairwoman.

24 CHAIRWOMAN OLSON: Thank you, Mike.

1 Comments from the Board, please.

2 MR. JENICH: Good afternoon, Madam Chairman
3 and respected members of the Board. My name is
4 Gerry Jenich -- that's G-e-r-r-y, J-e-n-i-c-h -- and
5 I am the manager for the applicant TCO JV, LLC, for
6 Project No. 15-044.

7 I'm pleased to have with me today Mr. John
8 Kniery, our CON consultant, and Mr. Daniel Lawler,
9 our CON counsel. Also present and available to
10 answer any additional questions you may have are
11 Mr. Charles Foley, our CON consultant, and Mr. Andy
12 Van Zee, associate counsel for the Main Street
13 Property Group, and he also represents the
14 co-applicant for this project, MS McHenry, LLC.

15 I would first like to thank and recognize
16 Mr. Constantino and Mr. Roate for their work on the
17 State Board staff report and to the entire staff for
18 providing us with technical assistance throughout
19 this process. They have been most helpful, timely
20 in their responses, and competent in performing
21 their duties. Thank you.

22 We are here today to respectfully ask for
23 your consideration and approval for the establishment
24 of a purpose-built 98-bed all-private-room skilled

1 nursing facility.

2 The physical plant will be a two-story
3 state-of-the-art inpatient transitional care
4 facility designed specifically to meet the growing
5 needs of patients that are requiring inpatient
6 rehabilitation, medical and physician services that
7 are transitioning from the hospital to their home.
8 This project is unique in that it will be physically
9 located on a hospital campus and is being planned
10 with the hospital's collaboration and input.

11 This project is being provided in response
12 to the State's identified need for additional
13 nursing beds. It is also the result of the
14 applicant being the successful respondent to a
15 comprehensive request for proposal process conducted
16 by Centegra Hospital in McHenry.

17 Our project file contains a letter from
18 Centegra's COE, Mr. Michael Eesley, stating that in
19 early 2015 Centegra Health System solicited proposals
20 from potential partners to create a postacute care
21 facility on the campus of Centegra Hospital in
22 McHenry to meet the identified bed need for long-
23 term care beds.

24 We were the successful respondent to the

1 RFP, and as you saw this morning, Centegra strongly
2 supports our application. All zoning and financing
3 requirements for this project have been satisfied,
4 and the project only waits the approval of the Board.

5 Regarding the applicants, by way of
6 background, I am manager for the applicant TCO JV,
7 LLC. I've been blessed with serving in the health
8 care profession for nearly 40 years. I initially
9 started as a certified nursing assistant and became
10 a licensed registered nurse, a paramedic, a hospital
11 administrator, and for 12 years I was divisional
12 vice president of operations for a large national
13 nursing home chain where I oversaw the daily
14 operations and performance of 125 nursing homes,
15 7 acute rehabilitation hospitals, and 2 acute long-
16 term care acute hospitals.

17 From 2005 to 2015 I served as chief executive
18 officer for a multistate Illinois provider of
19 skilled nursing and postacute facilities and
20 continue to function as a managing partner for that
21 organization today.

22 Over the last three years I have codeveloped
23 three new state-of-the-art transitional care
24 facilities just like the one being proposed for this

1 project in collaboration with the Main Street
2 Property Group, who is doing business on this
3 project as MS McHenry, LLC, as the coapplicant.

4 In addition, I was before the CON board in
5 2006 and received approval for what has proven to be
6 a very successful 150-bed transitional care facility
7 in Hanover Park.

8 As with Hanover Park and as manager for
9 TCO JV, LLC, I will be intimately involved in the
10 day-to-day management and oversight of the project
11 and resulting operations.

12 What is Transformative Health of McHenry?
13 Transformative Health of McHenry is intended to be a
14 purpose-built skilled nursing facility. The estimated
15 68,586-square-foot physical plant will be designed
16 with the specific purpose of serving the current and
17 future postacute care outplacement, medical, and
18 market demands of consumers, hospitals, and health
19 care providers in an evolving Accountable Care Act
20 world.

21 As you are well aware, our health care
22 system is undergoing rapid and watershed changes.
23 Government mandated initiatives like bundled
24 payments, value-based purchasing, quality measures,

1 and other risk-sharing programs are driving both
2 hospital and skilled nursing providers and physicians
3 to rethink care delivery models and collaborate in
4 innovative ways as a means to survive and thrive now
5 and in the future. We are challenged to
6 simultaneously improve health care delivery and
7 control or reduce related costs.

8 Over the next 10 years, if not all -- many,
9 if not all State and Federal payment programs are
10 expected to transition to and be operating in a
11 purely managed care environment. Traditional
12 fee-for-service payment programs, including Medicare,
13 will become managed care.

14 As it so happens, I also oversee operations
15 in Arizona, and Arizona today is an example of a
16 state that is nearly 100 percent managed care.

17 Innovative health care systems like Centegra
18 are looking to the future, and projects like this
19 one are rapidly becoming more prevalent as acute and
20 postacute care providers across our country
21 collaborate and reposition themselves to respond to
22 meet these changes.

23 Transitional Health of McHenry will
24 differentiate itself from existing providers in

1 multiple ways.

2 First, this is a project designed in
3 collaboration with a hospital provider to meet
4 identified shortfalls or unmet needs in the primary
5 and secondary service area.

6 Second, the applicants have collaborated on
7 a strategic level with Centegra Hospital McHenry to
8 create a noncaptive, postacute provider relationship
9 designed to meet the current and future demands of
10 delivery and payment models now affecting hospitals
11 and health care providers on every level.

12 Most importantly, this is a project that
13 should not be thought of in traditional terms but
14 rather seen as an innovative project that would set
15 the standard for future hospital-postacute care
16 delivery systems.

17 Transformative Health of McHenry is a
18 project that I humbly request you to consider for
19 approval based on the following response and defense
20 to any negative finding in the State's report.

21 Mr. Kniery.

22 MR. KNIERY: If I can address those negative
23 findings.

24 The State Board shows 18 criteria being

1 satisfied with only two resulting findings. Those
2 two findings relate to one central issue, the
3 underutilization of existing facilities. There is a
4 meaningful and justified response to these findings.

5 The State has an updated inventory of health
6 care facilities and services and need determinations
7 which use a more confident five-year projection that
8 is steeped in historical utilization. The 2015
9 inventory has a 2013 base year, and the need is
10 projected out to 2018. This need is not for here
11 and now; it's for 2018. We will be -- our first
12 full year of operation under the State's rules will
13 be in 2019.

14 This shows a more confident, conservative
15 inventory. It shows an outstanding need for
16 127 nursing beds. This project is only for 98.

17 The project has been developed in
18 collaboration between Centegra Health Systems,
19 specifically Centegra Hospital McHenry, whereby, the
20 applicant intends to help address industry pressures
21 that are pushing patients out of the hospitals sooner
22 and requiring better outcomes in terms of lower
23 rehospitalization and greater customer satisfaction.

24 These measurements and pressures will continue

1 to impact how hospitals and skilled providers
2 receive compensation for services under the value-
3 based purchasing and bundling initiatives. This
4 project addresses these issues by providing more
5 services in a more efficient environment that
6 improves patient outcomes. It improves patient
7 satisfaction, lowers rehospitalization rates, and
8 ultimately reduces total health care costs.

9 The reason that there's a bed need in the
10 planning area of McHenry County is the fact that the
11 65-plus elderly population has grown or increased at
12 a rate of 29.2 percent according to the State's data.
13 Also according to the State's data the same age
14 cohort statewide has only grown by 15.8 percent or
15 roughly one-half that of the planning area. The
16 resulting ratio of beds to population, another
17 indicator of need for the market area, is one
18 nursing home bed for every 46.6 elderly. Whereas,
19 the State's ratio is one bed for every 20 elderly.
20 In other words, the McHenry County planning area has
21 less than half the beds per capita than the rest of
22 the State.

23 Just in summary, the updated bed need
24 projection shows a need for the requested beds. The

1 growth in the 65-plus age group cohort for the
2 planning area is nearly two times higher than the
3 State's average and shows a comparably lower number
4 of nursing beds to service the existing population.
5 These facts, combined with the consideration of the
6 strategic planning on behalf of the primary service
7 area's primary health care provider should be made
8 part of your evaluation.

9 MR. JENICH: Dear respective members of the
10 in Board, in closing please consider the following
11 differentiating characteristics of this application:

12 The applicant TCO JV, LLC, is the successful
13 respondent to a comprehensive request for proposal
14 initiated by Centegra Hospital in McHenry for
15 providing postacute and transitional health care and
16 services to be located on the hospital's campus.

17 There is a calculated bed need inventory,
18 and the elderly population is growing at two times
19 the rate of the state average for the primary
20 service area.

21 Changes to the health care delivery system
22 and payment methodologies are driving innovation in
23 the delivery of postacute and transitional care
24 services like this project and the other CON and

1 Illinois project referenced earlier by this
2 applicant.

3 This project has received a completely
4 positive financial review by the staff, and no
5 public hearing was requested.

6 We thank the Board for its consideration and
7 would be pleased to address any questions you may
8 have for us at this time.

9 Thank you.

10 CHAIRWOMAN OLSON: Thank you.

11 Questions?

12 Mr. Sewell.

13 MEMBER SEWELL: I want to ask Mr. Constantino
14 a question about the letter from Mr. Tecson.

15 Have you had a chance to look at that where --
16 calling into question the positive State agency
17 finding on 1125.540. It's the one where -- the
18 writer of this letter asserts that -- a conclusion
19 as to whether the application meets this 1125.540 is
20 satisfied is wrong, and it has to do with it being
21 based upon the expectation of referrals coming into
22 the proposed facility from, I believe Centegra Health
23 System. Have you had a chance to look at that?

24 MR. CONSTANTINO: We extended the review for

1 this project and addressed some of these issues, and
2 that was one of the issues we addressed. We got
3 further information regarding that, and we went
4 ahead and accepted the explanation from the hospital
5 and accepted the referrals, and that's stated in our
6 report that the referrals were accepted.

7 MEMBER SEWELL: Okay. So in the opinion of
8 the staff, you would still stand by the --

9 MR. CONSTANTINO: Yes, in the opinion of the
10 staff --

11 MEMBER SEWELL: -- fact that that criteria
12 is satisfied?

13 MR. CONSTANTINO: That is correct, yes. Our
14 rules ask for physician referrals or hospital
15 referrals, and those referrals were coming from the
16 hospital Centegra.

17 MEMBER SEWELL: Thank you.

18 CHAIRWOMAN OLSON: But it doesn't ask who
19 they're taking them away from?

20 MR. CONSTANTINO: No, no, it didn't.

21 CHAIRWOMAN OLSON: Mr. Hayes.

22 VICE CHAIRMAN HAYES: Thank you.

23 Could you go over the ownership interests in
24 TCO JV, LLC? Who owns that?

1 MR. JENICH: It is a joint venture that is
2 owned between the Main Street Property Group entity,
3 MS McHenry, LLC, and a group of investors on the --
4 in an entity called JNV and Associates, LLC. The
5 joint venture is a representative split on both
6 operations and real estate.

7 VICE CHAIRMAN HAYES: Okay. So MS McHenry,
8 what is their interest in this?

9 MR. JENICH: Development and holding the
10 rights to the real property.

11 VICE CHAIRMAN HAYES: Okay. And then the JV
12 has a variety of investors; is that correct?

13 MR. JENICH: Yes, sir, and that's the
14 operator or that's the operating entity that's
15 created for the single-purpose entity associated
16 with the project, not uncommon for other projects.

17 VICE CHAIRMAN HAYES: Well, is the -- you
18 know, basically, the JV, does one of the -- does
19 that have someone in there that is basically Centegra
20 Hospital?

21 MR. JENICH: No. Centegra does not -- is
22 not a coapplicant, and Centegra is not an investor
23 or an owner in the project itself. The project
24 calls for the -- a land lease between the operator

1 and the hospital for the land associated with the
2 project.

3 VICE CHAIRMAN HAYES: Now, what is the --
4 MS McHenry, they basically have -- they're providing
5 the mortgage for this project?

6 MR. JENICH: They provide the financing,
7 yes, and the mortgage. Correct.

8 VICE CHAIRMAN HAYES: And I was wondering on
9 the State agency report on the -- you know, basically
10 page 6 of 19 and the project cost and sources of
11 funds. Here it lists cash and securities. It
12 doesn't talk about a mortgage at all.

13 MR. JENICH: Correct. This is an all-cash
14 project. So there's no financing contingency
15 associated with it. The Main Street Property Group
16 will hold the real estate as part of the project,
17 not finance related. There's no debt.

18 VICE CHAIRMAN HAYES: But they are providing --
19 they're giving you about -- how much is it? I read
20 somewhere it's about \$16 million.

21 MR. KNIERY: They are providing the funding
22 for the project, the funding through internal
23 sources, and we can have Andy Van Zee, Mr. Van Zee
24 address your concerns if you'd like.

1 VICE CHAIRMAN HAYES: Well, yes.

2 CHAIRWOMAN OLSON: Would you please be
3 sworn in.

4 (Witness duly sworn.)

5 MR. VAN ZEE: Would you mind repeating the
6 question so I can understand it more clearly?

7 VICE CHAIRMAN HAYES: Basically, MS McHenry
8 is, you know, providing the funding for this project
9 and is also -- they own the real estate and things
10 like that, and they're providing a mortgage for this
11 project. And I was wondering, why hasn't that been
12 recognized as a mortgage as opposed to a cash and
13 securities.

14 MR. VAN ZEE: This is an all-cash deal.
15 There is no -- in the sense of a mortgage because
16 we're not controlling the real estate. That will be
17 a land lease. We will just be building the actual
18 physical structure with 100 percent cash funding
19 from Main Street and then leasing that to TCO JV.

20 MR. KNIERY: That's also shown on page 28 of
21 the report -- I'm sorry -- the application itself
22 and concurred, I believe by Mike Constantino's
23 review.

24 This is a cash project. We did supply a

1 document that the cash is available and will be used
2 for the project.

3 VICE CHAIRMAN HAYES: And, thus, the
4 operating entity will be paying a lease, basically?

5 MR. KNIERY: That is correct.

6 MR. VAN ZEE: Yes. That is correct.

7 VICE CHAIRMAN HAYES: Okay. Now MS McHenry,
8 there isn't any -- Centegra doesn't own any of that
9 either?

10 MR. VAN ZEE: No. MS is a single-purpose
11 entity. It's parent company is Main Street Property
12 Group which is all owned by -- it's all privately
13 owned with zero investment from Centegra in any way.

14 MR. KNIERY: If I may, I was told today even
15 that hospitals don't want to do nursing home work,
16 and I don't think the nursing home providers want to
17 do hospital work. So they are only the landlord of
18 the ground lease.

19 VICE CHAIRMAN HAYES: Now, the operating
20 company, the JV, that operating company, are you the
21 only employee of that company?

22 MR. JENICH: No, sir. There's three to
23 four primary managers associated with the legal
24 entities. I'm one of the managers, and there's

1 two managers -- there's another manager position
2 that if the project is approved will be filled per
3 the operating agreements between MS McHenry and
4 TCO JV, LLC, and then MS McHenry has two managers
5 that are also part of that joint venture.

6 VICE CHAIRMAN HAYES: All right. Thank you
7 very much.

8 MR. JENICH: Thank you, sir.

9 CHAIRWOMAN OLSON: Other comments or
10 questions?

11 Mr. Burzynski -- Senator.

12 MEMBER BURZYNSKI: Thank you. Just a couple
13 points of clarification.

14 So Centegra currently owns the property, and
15 they are leasing the property to MS McHenry? Is
16 that what I am to understand?

17 MR. JENICH: That's correct. If the project
18 is approved -- it's contingent on approval from the
19 Board, but we have an agreement of commitment from
20 Centegra that we would enter into a land lease
21 agreement with them for the property.

22 MEMBER BURZYNSKI: So they do have a
23 financial interest in the project of some sort
24 because of the lease?

1 MR. JENICH: They have an interest in the
2 project because of its location on their campus, and
3 I can't speak for them, but they have no financial
4 interest in the day-to-day operations of the project
5 itself.

6 MEMBER BURZYNSKI: Right. Okay. Thank you.

7 Another follow-up question. You indicated
8 just a few minutes ago about the ratio of beds
9 available per population -- one of you did; I don't
10 remember exactly -- and that McHenry is so much
11 higher than the state average. Do you have any
12 reasoning why that might be?

13 MR. KNIERY: We can only surmise but there
14 hasn't been -- with the exception of, I believe the
15 Alden facility in Huntley, there hasn't been a new
16 facility there for quite some time, and I know that
17 the previous project that tried to get approved that
18 the same opposition was there.

19 MEMBER BURZYNSKI: And I'm guessing that the
20 population increase is because of Huntley and the
21 retirement village there.

22 MR. KNIERY: That was a significant part of
23 it, but that was addressed, I think in their
24 project, and that was several years ago and that

1 includes those beds.

2 MEMBER BURZYNSKI: So the growth has
3 continued, though, in the population base over the
4 age 65?

5 MR. KNIERY: Based on -- this is Alden
6 Estate's inventory data. We didn't look at an
7 outside source. We didn't look at Scan U.S. We did
8 provide the census data just because the rules asked
9 for it, but this is based on the State's inventory.

10 MEMBER BURZYNSKI: And then I also notice in
11 our notes, and I think you all have indicated, as
12 well, that you anticipate that there will be
13 approximately 30 percent of the -- I think someone
14 argued the term referrals, but 30 percent of the
15 referrals from Centegra will be coming to the new
16 facility. And my question is, what impact do you
17 think -- regardless of the terminology you want to
18 use, what impact do you think that will have on the
19 existing facilities where 9 of 11 of those in the
20 immediate area are underutilized and some as low as
21 I think -- I don't remember what it was, but it
22 seemed like it was down in the 20s or 30 percent.

23 MR. KNIERY: I think -- I think anytime
24 there's a new project that there is an impact. I

1 think what we're seeing, also, though, is we're
2 seeing a change in the health care delivery system.
3 We're only a few years now into the Affordable Care
4 Act. As this starts ramping up and all facilities
5 are buying in and pressures are put on the acute
6 care providers, we're seeing people move downstream.

7 So, yeah, I think there will be an impact
8 initially. I also think that more people are being
9 discharged quicker. I think that in itself will
10 create a demand.

11 Gerry, what else would you add to that?

12 MR. JENICH: I think, obviously, based on
13 the opposition to the project there's a lot of
14 concern from existing providers that it will have a
15 negative impact on operations and performance. And
16 being an operator, being a nursing home operator and
17 having been in this business for a very long time,
18 and looking at how we need to continue to position
19 providers to be successful in this changing world of
20 payment and delivery, I wanted to say a couple things.

21 One, I have the utmost respect for the
22 existing providers in the service area. They do a
23 good job; they provide good services, and I can
24 understand their opposition. If I'm on the other

1 side, I'm concerned about the impact a project like
2 this has on my operations.

3 I'm also worldly enough to know that the
4 world is changing. And this Board has seen projects
5 like this presented to it recently, another project
6 that was presented this morning that was very, very
7 similar. One of the only differentiating
8 characteristics is that there's not as much opposition
9 there as there is here.

10 We worked with Centegra on this project
11 based on the fact, one, there's an established bed
12 need. Had that not been part of the State health
13 plan and had we not been subject to CON review, you
14 know, it's a whole different ball game. But the
15 State has identified that need. The project
16 inventory has been updated in the last several years
17 to reflect that there's actually greater need than
18 what was there previously.

19 I think, you know, in an unrelated case the
20 Board had looked at another project a number of
21 years ago, and this project makes a lot of sense.
22 It's different. It makes a lot of sense. I think
23 there's still a place for the existing providers.

24 The hospital is always quick to point out to

1 us even in their letters that hospitals don't make
2 referrals. If you talk to the hospitals very
3 closely, they'll say even the doctors don't. They
4 give patients a choice, and the consumer today in
5 health care is much more intelligent than they have
6 been in the past. They look at quality ratings;
7 they look at performance; they look at the condition
8 of the fiscal climate, and we all make decisions
9 about where we go for our own health care services
10 and services that we want our loved ones to have.

11 Projects like this are the future. Centegra
12 is being very forward looking and still being
13 realistic that they want to support their client
14 base, as well.

15 So the estimate of 30 percent of the
16 hospital discharges, if you will, coming to this
17 project is probably a realistic yet -- probably a
18 realistic estimate of what it can expect to receive.
19 The project will also take its fair share of charity
20 services, the same percentages that we see coming
21 out of the hospital.

22 The pressures that we're under as nursing
23 home providers, including the folks that testified
24 this morning for shorter length of stay, for being

1 dictated what it is they're going to get paid for
2 services require us to look at things very
3 differently and more efficiently.

4 When you can build a facility today to scale
5 both in the size of number of beds and patient rooms
6 and you can outfit that facility with the right
7 physician and medical services, we're not trying to
8 reinvent what could be an aging model. You have the
9 ability to reduce costs into a group there, and
10 that's what both acute and postacute care providers
11 are being challenged to do today.

12 MR. KNIERY: If I can add one other point,
13 we are addressing future need. That bed need that's
14 in place now, to truly understand it, a bed need
15 does not result -- you don't find additional beds
16 needed until the existing capacity at 90 percent is
17 filled. That's an inherent assumption with the
18 current need -- the way the formula is built. If it
19 doesn't come, there's a lot of reasons for that.

20 CHAIRWOMAN OLSON: Mr. Sewell.

21 MEMBER SEWELL: Yeah. I want to paraphrase
22 your argument as to why the two negative findings
23 should be positive, and then I want you to tell me
24 what I said that you said that's incorrect.

1 It seems like you were arguing that in about
2 three years, even if you add 98 beds to the inventory
3 with your project, you will have occupancy rates for
4 the facilities that are within the -- I think it's
5 30 minutes that's on the table -- you'll be up to
6 90 percent in three years.

7 In other words, there's going to be an
8 increase in demand; there's the aging of the
9 population that is more in that area than the
10 average for Illinois, and you're going to see this
11 type of -- you're going to see the utilization
12 standard essentially being met even if you add more
13 bed capacity to the area in about three years.

14 So is that what you're saying?

15 MR. KNIERY: I'm saying that's what the model
16 shows, the bed need model, the State's bed need
17 inventory. That's how -- that's what it shows.

18 Now, you're touching on an issue -- will
19 that really happen I'm assuming is your next
20 question, will that really happen. We had a large
21 bed need, there was a 10-year projection when a
22 previous project was looked at, and I think this
23 Board wisely said, well --

24 MR. MORADO: John, could I just have you

1 talk about your project, please.

2 MR. KNIERY: So there has been -- even the
3 previous -- this project came out, I believe in
4 August, the inventory came out in August of last
5 year. The previous inventory which was a five-year
6 projection showed about 100 beds, and now we're
7 showing 127 beds. We didn't want to push the
8 envelope for the 127. I think we wanted to leave
9 room for providers.

10 That being said, the existing providers, to
11 make themselves marketable, to get those people,
12 yeah, they could. I don't know if all the beds are
13 set up and staffed. I think we can look at all the
14 profiles; I think that's been hashed and rehashed.
15 There's an issue of potential dead beds; there's
16 issue of -- if you have a double room and you have
17 an isolation issue, that takes a bed out. There's a
18 lot of that that we see. That's why a facility that
19 has all private rooms is something that you're going
20 to see a lot more of in the future.

21 So there's issues. I'm not going to sit
22 here and say that, oh, yeah, they're all going to be
23 at 90 percent, but I think there's outstanding issues.

24 VICE CHAIRMAN HAYES: Okay. A technical

1 question to Mike.

2 Why wasn't the mortgage included in this
3 project? Then it would require viability ratios to
4 be able to look at the financial feasibility.

5 MR. CONSTANTINO: Yes. We went under the
6 assumption that it was going to all be funded by
7 cash and that's what we accepted. That was the
8 attestation made by the applicants.

9 VICE CHAIRMAN HAYES: But that's not what
10 happened, is it? I mean, aren't they going to have
11 a mortgage essentially? What is the difference?

12 MR. CONSTANTINO: My understanding of this
13 model is there's an entity set up to operate the
14 facility, and they'll be leasing that facility from
15 another entity who owns the real estate or the
16 building.

17 VICE CHAIRMAN HAYES: Yes.

18 MR. CONSTANTINO: That's the entity that
19 will carry the mortgage. All they'll be doing is --
20 all the operating entity will be carrying is the
21 lease. They'll be making the mortgage payments --
22 or the lease payments -- I'm sorry.

23 VICE CHAIRMAN HAYES: Well, they do get the --
24 what is the difference in what we see in many other

1 projects that have a mortgage? Why is this so
2 different?

3 MR. CONSTANTINO: That I couldn't answer for
4 you, John. We went under the assumption it was all
5 going to be internally funded by cash and that's
6 what we accepted, and they provided the financial
7 statements, audited financials that indicated they
8 had sufficient cash to fund the project.

9 VICE CHAIRMAN HAYES: And this was what, by
10 the operating entity or MS McHenry?

11 CHAIRWOMAN OLSON: MS McHenry. Right?

12 MR. CONSTANTINO: Main Street Property
13 Group, LLC, who is a coapplicant on this application
14 was the financier for the project, and there was
15 sufficient cash to fund the project, and we accepted
16 that from review of their audited financial
17 statements.

18 VICE CHAIRMAN HAYES: Now, when they finish
19 making payments, their lease payments, who will own
20 this property?

21 MR. CONSTANTINO: The owner of the property
22 will remain. The lease payment doesn't entitle them
23 to the ownership of the property. The operating
24 entity won't own the property; they'll just continue

1 to make the lease payments.

2 VICE CHAIRMAN HAYES: Okay. Is there any --
3 does this mortgage -- or does this have any terms
4 associated with it?

5 MR. JENICH: The -- I may have misspoke
6 earlier, Vice Chairman. There's not a mortgage
7 associated with this. I may have misspoke earlier.
8 There's not a traditional mortgage associated with
9 this because it is all cash to fund the construction.
10 The operator will lease the physical plant from the
11 owner, but the owner and the operator are joint
12 venturing in this.

13 So it is a means to pay back the money
14 involved with establishing the project, but it is
15 probably a 30-year initial lease between the
16 operator and the real estate entity.

17 VICE CHAIRMAN HAYES: Do you have any -- you
18 know -- do you have any terms with that? You know,
19 an interest rate -- the 30 years is the length of it?

20 MR. JENICH: We have operating agreements
21 that will be finalized if the project were to be
22 approved, operating agreements between the operator
23 and the real estate holder or the real -- the holder
24 of the real entity, which is the bricks and mortar.

1 VICE CHAIRMAN HAYES: Okay. This is --
2 anyway, okay. Thank you very much.

3 MR. KNIERY: If I may, on page 45 of the
4 certificate of need application, we're looking at
5 initial lease term of 50 years. The letter of
6 intent for the lease is in the application.

7 MR. CONSTANTINO: John, where are you getting
8 the mortgage? I'm looking through the application.
9 I can't find a mortgage stated in here.

10 VICE CHAIRMAN HAYES: Well, in normal --
11 isn't it the case that if these funds are being
12 provided, even though it -- you know, if they're the
13 entire 100 percent of this facility, shouldn't that
14 be considered a mortgage?

15 MR. CONSTANTINO: No. We accepted Main Street
16 Property Group as providing \$19 million in cash to
17 fund this project.

18 VICE CHAIRMAN HAYES: I understand that.

19 MR. CONSTANTINO: And they were an applicant
20 on this application. There was never a mortgage
21 mentioned in the application, and they gave us no
22 indication until today that that could be the case.
23 There's nothing in the application to identify a
24 mortgage with this application. I don't know where

1 that's coming from.

2 CHAIRWOMAN OLSON: They're saying there's no
3 mortgage.

4 MR. LAWLER: That's correct. The property
5 is owned by Centegra, and it's on their campus, and
6 Mr. Van Zee, the coapplicant here, is leasing that
7 property from Centegra, and they're also with cash
8 building the building on the property that's leased
9 from Centegra.

10 So Mr. Jenich, unfortunately, misspoke when
11 he made a reference to a mortgage. There is no
12 mortgage involved in this, and the property
13 acquisition which is not part of a CON project, the
14 real estate is owned by Centegra being leased to the
15 other coapplicant.

16 THE COURT REPORTER: I'm not sure you stated
17 your name.

18 MR. LAWLER: My name is Dan Lawler,
19 L-a-w-l-e-r.

20 CHAIRWOMAN OLSON: Mr. Sewell.

21 MEMBER SEWELL: I'm still on 1125.570 and
22 1125 -- the two offending criteria.

23 This argument that if you project them out
24 to 2019, which is when the project comes online,

1 then there is sufficient demand, do we do that? Do
2 we look at when a project is coming online and then
3 project the need?

4 MR. CONSTANTINO: We project it out to 2018,
5 our five-year inventory projections, which is
6 Calendar Year 2018. We're projecting the need in
7 this area for 127 beds by Calendar Year 2018, and
8 that's based on historical utilization, plus a
9 growth in population in that area.

10 MEMBER SEWELL: And they're adding --

11 MR. CONSTANTINO: And they're suggesting
12 that these facilities could be at 90 percent by
13 2019, the first year after project completion.

14 Generally, what we're seeing throughout --
15 generally what we're seeing is about 80 percent in
16 these facilities, between 78 and 80 percent.

17 MEMBER SEWELL: But you -- but you have a
18 negative finding on these?

19 MR. CONSTANTINO: Yes, yes.

20 MEMBER SEWELL: Because you don't agree with
21 the assumptions that they're making?

22 MR. CONSTANTINO: We looked at it and these
23 facilities were underutilized -- currently
24 underutilized, which we're required to do and are

1 required because of a court ruling to consider, and
2 that's what we did in that case for service access
3 and unnecessary duplication of service.

4 MEMBER SEWELL: Thank you.

5 CHAIRWOMAN OLSON: I actually have some
6 questions. I've waited patiently.

7 Doctor, did you want to --

8 MEMBER GOYAL: I did but I had two comments --
9 and you can respond if you'd like -- in response to
10 what you said that the physicians make the referrals
11 the hospitals don't. That's what I understood and I
12 want to say one thing.

13 In the state of Illinois and almost nationally
14 the numbers are 40 to 60 percent of the physician
15 practices represent employee physicians today, which
16 means if you're employed by the hospital, the one who
17 pays your paycheck controls where your patients go.

18 The second point I want to make, having served
19 as a utilization consultant for a 300-, 400-bed
20 hospital in the suburbs, I could tell you that if
21 your discharge plan -- and there were 13 of them --
22 if a discharge planner comes back and says, "I can
23 transfer this patient today to this facility on our
24 grounds if you wish. Otherwise, we can wait until

1 the facility you or the patient prefers can take
2 them which would be several days," where would the
3 patient go?

4 So just for your information -- and if you
5 disagree, please say so.

6 MR. KNIERY: Doctor, your first comment --
7 and I think Mr. Jenich said the hospitals were
8 saying that they don't make referrals; they offer
9 choices to patients and their families. But the
10 second comment with the doctors was they would
11 contend the doctors also -- it takes a doctor's
12 order to admit, obviously, to a skill nursing
13 facility. But the hospitals -- it's been told to us
14 that they would intend also that the doctors also
15 give the choice.

16 That was the only comment. We weren't
17 implying that the doctors are -- yes, it does take
18 referrals; it does take -- from both the hospitals
19 and the doctors. It's just a little bit further.

20 MEMBER GOYAL: The dynamics are changing.
21 That's all I wanted to say.

22 MR. KNIERY: Correct.

23 CHAIRWOMAN OLSON: I have a question.

24 So I'm making the assumption based on what

1 you said before and I want you to confirm or deny
2 that you will not be accepting any Medicaid patients
3 at this facility.

4 MR. JENICH: No, that's incorrect. We will
5 be accepting Medicaid patients at this facility.

6 CHAIRWOMAN OLSON: Can you explain for me
7 what you see as your typical patient? Because I
8 believe you're holding yourself out as being
9 different than all of the other long-term care
10 facilities, so I need you to explain to me how
11 you're different.

12 MR. JENICH: One of the challenges today for
13 acute care providers is exactly as Dr. Goyal
14 suggested, that hospitals are looking -- are
15 challenged to move patients out into either a home
16 environment or postacute care environment.

17 Given the title of a transitional care
18 facility, keying in on the word transition, helping
19 them manage those patients that are going from a
20 hospital environment to a home environment. So we
21 typically see a shorter length of stay-type patient,
22 more intensive rehab services, we -- providers will
23 traditionally talk about an orthopedic patient who
24 is undergoing a knee replacement or hip surgery, and

1 they come in, they need physical or occupational
2 therapy, and they're transitioned to home. In reality
3 almost every patient coming out of the hospital
4 benefits from some postacute inpatient service.

5 So while what we expect to see in this
6 facility are those types of patients, we expect to
7 see, also, long-term care patients as we see that
8 people that come in and are not able to go home for
9 some reason and would have an extended stay in this
10 type of facility, and we expect to be able to see a
11 representative proportion similar to what we're
12 seeing coming out of the hospital demographics right
13 now for Medicaid services for this facility, as well.

14 CHAIRWOMAN OLSON: So based on everything
15 that you just said, how are you different than the
16 other facilities that sat at that table today and
17 said, "You're going to hurt our business by opening
18 this facility"? How are you different?

19 MR. JENICH: We specialize in services that
20 are able to handle that level of acuity coming out
21 of the hospital. We specialize in having personnel,
22 programs, and equipment that focus on preventing
23 rehospitalizations within 30 days. All providers
24 today are challenged to do that. All providers

1 today that are looking to establish a relationship
2 with a hospital are under quality measures for
3 performance. These facilities seem to perform much
4 better than facilities that don't specialize in it,
5 that don't concentrate and focus on how you manage
6 those rehospitalizations. In the long run you're
7 saving health care costs for both acute care and for
8 postacute care.

9 CHAIRWOMAN OLSON: Isn't that based on that
10 you're not going to accept the high-acuity patient
11 that these long-term care facilities have to accept
12 by virtue of what they're doing? You're not going
13 to have a trach patient that's going to be there for
14 the rest of their lives, has been there for ten years.
15 It's a lot easier to have better outcomes based on
16 what is the kind of patient that I believe you're
17 trying to go after.

18 But I still don't believe my question has
19 been answered. How are you different? What do you
20 anticipate your average length of stay to be?

21 MR. JENICH: Average length of stay is
22 probably around 28 days. We're seeing that --
23 nationally you're seeing that trend even grow
24 shorter.

1 CHAIRWOMAN OLSON: So then how do you --
2 because you just told me you're going to take high-
3 acuity long-term patients, so you anticipate
4 patients that are going to be there for the rest of
5 their life or you don't.

6 MR. JENICH: You do end up in these types of
7 facilities with patients that will stay.

8 Can I go back for a second to your comment
9 about acuity? These facilities take higher acuity
10 than traditional nursing homes. Patients are coming
11 out -- the term is called "sicker and quicker" out
12 of the acute care environment. They're coming to
13 postacute care providers much more acute than what
14 we've seen in the past. So you need midlevel
15 practitioners that are in the building really almost
16 24 hours a day, physician extenders that are there
17 to be able to monitor and treat any changes that
18 occur in the patient's condition.

19 Traditional providers have units that
20 provide those services, but the building doesn't
21 specialize in them. So there are changes in
22 condition; there are changes in -- the patient's
23 condition can change very quickly and very rapidly,
24 resulting in readmission to the hospital which under

1 the ACA and now hospitalists are penalized.

2 CHAIRWOMAN OLSON: I understand.

3 MR. JENICH: So hospitals are looking for
4 providers that have experience in this area;
5 hospitals are looking for providers that can manage
6 that acuity and manage that recidivism as a means to
7 control expenses and still have good outcomes.

8 One of the other big differentiating
9 characteristics in a facility like this is your
10 customer satisfaction rates. You've got all private
11 rooms. There's a medical benefit to that as well as
12 an aesthetic benefit. The medical benefit is you
13 don't have cross contamination. People that come
14 out of the hospital typically come out with what's
15 called MRSA.

16 CHAIRWOMAN OLSON: I understand that.

17 MR. JENICH: So you don't have any cross
18 contamination. If you're a surgical patient, your
19 risk of developing an infection in the wound is much
20 less because you're in all-private facility. Your
21 customer satisfaction ratings are very, very
22 important. Payers today -- particularly the
23 hospitals -- are rating them on what kind of
24 experience you or I have in that hospital setting or

1 what kind of experience you or I have in a postacute
2 care center. Payment can be affected by that in the
3 future.

4 CHAIRWOMAN OLSON: Understood. So if I have
5 my knee replaced next week, and I come to your
6 facility, when am I going to get my first treatment?

7 MR. JENICH: You're going to get evaluated
8 probably within the first -- right after your
9 nursing assessment is done probably within the first
10 two hours of your admission, and if your evaluation
11 is positive, you'll begin treatment the very next day.

12 CHAIRWOMAN OLSON: So it seems to me -- I'm
13 confused about what your market is. Because it
14 seems to me that that's the kind of patient you
15 want, but on the other hand, you're telling me
16 you're going to take that high-acuity patient who is
17 coming out sicker and quicker and going to be there
18 longer.

19 It sounds like you want to do what everybody
20 else is doing, and I don't understand how you -- I'm
21 just not wrapping my head around how you're different.
22 I don't understand how we're not going to hurt the
23 other facilities in the area that aren't at capacity.

24 I get what John's saying about the numbers,

1 but, please, I'm looking for an answer.

2 MR. LAWLER: Madam Chair, one of the things
3 that was commented on this morning by the Centegra
4 representatives is that they were looking for a
5 community provider that would help them improve the
6 health of the population they serve. They opened up
7 a process and accepted requests for proposals for a
8 facility that would help them improve the population
9 health and work with them to improve the population
10 health of McHenry County, and there was a selection
11 process that this applicant prevailed on. So their
12 facility will be on Centegra's campus, and they will
13 be working with Centegra to, among other things,
14 reduce the readmission rate to Centegra Hospital,
15 and this will help the hospital improve the outcomes
16 that everybody is trying to achieve.

17 So that is a distinction which is currently
18 not available in McHenry county.

19 CHAIRWOMAN OLSON: I can understand why the
20 other facilities that feel like they're offering the
21 service aren't going to throw their hats in the ring
22 when Centegra asks somebody to go on their property,
23 and it doesn't take a rocket scientist to figure out
24 why Centegra wants that building on their property.

1 If I'm a discharge planner, yeah, I want that
2 facility there because it's pretty darn easy just to
3 send them across the street.

4 But I still don't understand how you're
5 different than the other facilities who are trying
6 to provide the same service and feel as though
7 they're going to be cannibalized by the fact that
8 you're going to take the cream-of-the-crop patients
9 away from them, and they're going to be left with
10 the Medicaid patients with high acuity in their
11 facility for the rest of their natural lives, and
12 they're doing their best to take care of them. I
13 can't get my head around it, and I guess it's just
14 my issue.

15 Thank you. Other questions or comments from
16 Board members?

17 (No response.)

18 CHAIRWOMAN OLSON: Seeing none, I'll ask for
19 roll call vote on Project 15-044, Transformative
20 Health of McHenry County in McHenry.

21 MR. ROATE: Thank you, Madam Chair. Motion
22 made by Senator Demuzio, seconded by Mr. Hayes.

23 Senator Burzynski.

24 MEMBER BURZYNSKI: Well, I appreciate the

1 candor of the gentlemen at the table because they've
2 answered I think all of the questions pretty well,
3 pretty openly, and I do appreciate that.

4 I am very concerned, however, with the
5 impact this could have and I believe will have on
6 the remaining facilities in the area, and because of
7 the summary of finds and the two criteria that are
8 not met, I'm going to have to vote no.

9 MR. ROATE: Thank you.

10 Senator Demuzio.

11 MEMBER DEMUZIO: Okay. After listening to
12 your comments and looking through your report, I,
13 too, have some concerns, and I think the duplication
14 of services, the fact that there's really not a
15 great deal of distance between any of you -- okay? --
16 and the fact that -- the issue of accessibility and
17 the duplication of services, I'm going to vote no.

18 MR. ROATE: Thank you.

19 Justice Greiman.

20 MEMBER GREIMAN: Well, we must have voted on
21 10 units, 10 today where they had less than 70 percent
22 use in the place, and yet we said, "Okay, go ahead."

23 I respect the answers that they gave.

24 Obviously, the finances with the mortgage -- with

1 the money used to build the building you're going to
2 have -- it's not very common anymore you have
3 somebody owns the land and somebody owns the
4 building, and that's what they're doing.

5 I don't see anything wrong with that
6 necessarily with \$19 million into the project. So
7 I'm going to vote aye.

8 MR. ROATE: Thank you.

9 Mr. Hayes.

10 VICE CHAIRMAN HAYES: Yes. I'm going to
11 vote no based on the State agency report, service
12 accessibility and also unnecessary duplication and
13 maldistribution, and this has to do with the impact
14 of project area -- of project area providers.

15 MR. ROATE: Thank you.

16 Mr. Johnson.

17 MEMBER JOHNSON: I'm going to vote no based
18 on the unnecessary duplication as outlined in the
19 report.

20 MR. ROATE: Thank you.

21 Mr. McGlasson.

22 MEMBER MCGLASSON: I'm going to vote yes
23 based on the fact that we do see a need upcoming,
24 and it appears that this facility would not be in

1 competition before it is dangerously close to not
2 being able to meet that need.

3 MR. ROATE: Thank you.

4 Mr. Sewell.

5 MEMBER SEWELL: I vote no based on the State
6 agency negative findings.

7 MR. ROATE: Thank you.

8 Madam Chair.

9 CHAIRWOMAN OLSON: I vote no based on the
10 State agency staff report findings.

11 MR. ROATE: Thank you. That's 2 votes in
12 the positive, 6 votes in the negative.

13 CHAIRWOMAN OLSON: The motion fails.

14 MR. MORADO: You're going to be receiving an
15 intent to deny notification from the Board, and
16 you'll have an opportunity to come back and appear
17 before the Board and submit additional information
18 if you desire.

19 Thank you.

20 MR. JENICH: Thank you very much.

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CHAIRWOMAN OLSON: Next we have H-12,
Project 15-051, Alden Estates-Courts of New Lenox.

May I have a motion to approve Project 15-051,
Alden Estates-Courts of New Lenox to establish a
140-bed long-term care facility? May I have a
motion?

VICE CHAIRMAN HAYES: So moved.

CHAIRWOMAN OLSON: And a second?

MEMBER SEWELL: Second.

CHAIRWOMAN OLSON: Mr. Constantino, your
report.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The applicants are proposing to establish a
140-bed long-term care facility in New Lenox, Illinois,
at a cost of approximately \$32 million. The
anticipated completion date is February 28th, 2019.
There was no public hearing, no opposition letters
received, and we did have findings on this project.

Thank you, Madam Chairwoman.

CHAIRWOMAN OLSON: Thank you, Mike.

Comments for the Board.

MS. SCHULLO: Hi. Good afternoon.

Randi Schullo.

1 Madam Chairman, members of the Board, I'm
2 Randi Schullo, president of Alden Management Services.
3 I'm pleased to have with me today Bob Molitor, our
4 chief executive officer; Tene Tillery, RN and
5 director of Alden's postacute services; John Kniery,
6 our CON consultant; Joe Ourth, our CON counsel, and
7 behind us we have Charles Foley if there's any
8 additional questions.

9 As always, I'd like to first thank
10 Mr. Constantino and Mr. Roate with their help with
11 the State agency report.

12 We are here to ask for your approval for a
13 new skilled long-term care facility adjacent to
14 Silver Cross Hospital in New Lenox. We are very
15 excited about this new project, as we will be the
16 first and only skilled nursing facility in the
17 village of New Lenox at this time.

18 I know we've presented to this Board
19 recently and feel that many of you know a little bit
20 about Alden and who we are and how we started.

21 Alden is a family-owned/operated provider
22 founded by my father, Floyd Schlossberg, here in
23 Illinois. We started as general contractors
24 building schools and park district facilities. In

1 1970 we built our very first skilled nursing
2 facility in Chicago which we still own and operate
3 today.

4 We currently have 35 facilities for which we
5 provide care to residents requiring skilled nursing,
6 postacute care, memory care, skilled peds, assisted
7 and supportive living. We also serve seniors
8 through our 10 affordable independent senior living
9 communities with our 11th under construction in
10 Woodridge.

11 We take pride in the quality of the facilities
12 we offer our residents. When we were here before
13 you, perhaps we talked too enthusiastically about
14 how nice our facilities are. We want to be sure we
15 didn't give you that false impression. We do have
16 quality facilities, but we do provide quality care
17 for all people.

18 Systemwide 75 percent of all Alden residents
19 are Medicaid. The majority of our beds in our
20 facility are Medicaid certified. We have developed
21 over 800 units of affordable independent senior housing
22 serving seniors 62 years of age and older, with our
23 average age being 79. These seniors are on fixed
24 incomes, and some live on less than \$10,000 per year.

1 MR. MOLITOR: My name is Bob Molitor,
2 M-o-l-i-t-o-r. I'd like to address the negative
3 findings.

4 I'd like to first point out the State Board
5 report made positive findings on all but three
6 criteria, among the findings -- the positive finding
7 that there is actually a 140-bed need within this area.

8 One negative finding was because this was a
9 new facility it could not meet all the financial
10 ratios, and two of the negative findings relate to
11 one issue, which is the underutilization at existing
12 facilities.

13 The concern about the underutilized
14 facilities is effectively addressed by the fact that
15 we had no facility express any timely opposition to
16 our project.

17 I'd like to move into why this is a good
18 facility for this location.

19 The first thing is the obvious one, there is
20 a bed need of 140 beds. This is a project that
21 we're doing in New Lenox which doesn't have its own
22 nursing facility within the area, and we have good
23 support from New Lenox, and they're projecting higher
24 population in New Lenox over the next few years.

1 We also have a great relationship, as you
2 saw by the comments from Silver Cross Hospital, the
3 group that was up here, and we already do some work
4 with Silver Cross Hospital in one of our facilities
5 from the postacute care side of the business. So
6 building that relationship has really been a good
7 thing for Alden and Silver Cross.

8 The unique part about our project compared
9 to everybody else is, something similar to what
10 we've done throughout our years with Alden, first
11 and foremost, I'd like to point out that we are
12 currently operating eight postacute care facilities
13 in the State of Illinois. They are purposefully
14 built and they do cater to the postacute care
15 population. But I also want to point out that our
16 model is a little different than everybody else's.

17 We just don't focus simply on the postacute.
18 This project in New Lenox not only will cater to
19 postacute care patients; it will have long-term care
20 patients. In addition to that, we have a separate
21 building that will be connected through a tunnel
22 that will cater to the Alzheimer's patient, and
23 those beds will also be skilled.

24 So in our minds, with the full continuum of

1 care being met, we're not only taking care of the
2 postacute care market. And I don't want to bore
3 you. Today you've heard a lot of testimony with
4 regards to what bundled care is and the Affordable
5 Care Act is and all that, but right now I think it's
6 more important to look at the difference in our
7 project, and our project really is a full continuum
8 of care.

9 Not only are we taking care of the
10 Alzheimer's patients whether they're public aid, or
11 private pay, or even Medicare care -- and there's
12 something specific to say about that -- when you
13 build a building as a postacute care provider or a
14 nursing home, you really have to have a separate
15 area, designated area for the Alzheimer's patients.
16 We're doing that with a separate building that's
17 connected underground. We use the same kitchen and
18 everything else but it's separate.

19 So what happens, too, is that if an
20 Alzheimer's patient or dementia patient happens to
21 fall and fracture a hip, we can actually take care
22 of Medicare patients within our Alzheimer's/dementia
23 unit because we're Medicare certified. So that's a
24 differentiation that we have in our project.

1 The other thing is that, like everybody
2 else, we're going to take public aid. We have
3 long-term care beds; we will have private rooms to
4 accommodate the -- and hopefully help out the
5 customer satisfaction-type thing. Right now we're
6 looking at across the board in our situation, we're
7 meeting and being a good neighbor to New Lenox and
8 providing all types of services to the community.
9 And, also, we are not specifically looking just for
10 hips and knees; we will be taking all types of
11 high-acuity level patients. Whether it's a trach
12 patient, whether it's IV therapy, we can take all of
13 those at this location.

14 One of the things that we have to point out,
15 and it's a realistic thing that happens in our
16 business today is that you have to have a good
17 relationship with a hospital because the hospital is
18 being judged in regards -- as relates to the
19 readmission rates to their hospital. So having a
20 good collaboration with a hospital, which we do, and
21 we do set aside specific people to help monitor
22 that, make sure our readmissions are low, and you
23 have to have a good collaboration, which means
24 resources from the hospital and resources from the

1 nursing home are working together to prevent those
2 rehospitalizations.

3 So that in a sense is what this whole
4 postacute care thing is about. The length of stay,
5 that's all very subjective in my opinion. If you
6 ask anybody, in most cases for health care they're
7 going to want a real low length of stay. I don't
8 know if that's realistic these days. Data will come
9 out in the next few years in regards to all these
10 judgments of whether or not the low length of stay
11 is good for postacute care.

12 In our minds we're looking at our
13 transitional postacute care patients probably being
14 anywhere between 14 and 18 days length of stay on
15 average. The long-term care patients will stay in
16 the building, and if we have some in between ones --
17 obviously, a trach patient would obviously be a
18 longer stay or a recent stroke patient would be a
19 longer length of stay. Hips and knees would be out
20 between 14 and 18 days.

21 One of the things I thought would be
22 beneficial today is if you heard from Tene some of
23 her experiences. She is the direct resource as the
24 director of postacute care services that works

1 directly with the hospital, and she can tell you a
2 little bit more specifically on how that collaboration
3 works and why that's a big difference between a
4 facility that doesn't have necessarily that type of
5 relationship.

6 MS. TILLERY: Good afternoon. My name --

7 THE COURT REPORTER: I can't hear you.

8 MS. TILLERY: Good afternoon. My name is
9 Tine Tillery. You spell the last name T-i-l-l-e-r-y.

10 As Bob said, I am the director of postacute
11 services for Alden, and I would just like to share a
12 little bit about kind of a typical patient, ortho,
13 cardiac patient and how this collaborative process
14 works within the facility.

15 Our transitional care nurse is a key role
16 regarding the collaboration between the hospital and
17 acts as a liaison between the hospital and the
18 facility, as well as coordinates care between both
19 organizations in implementation of our postacute
20 program within the facility on a daily basis and
21 ensuring that the treatment plans are followed per
22 our physician protocols.

23 The transitional care nurse, of course,
24 meets and greets the patient upon arrival to the

1 facility along with their family and there's also
2 a -- to ensure that there's a smooth transition from
3 the hospital to the facility. The transitional care
4 nurse oversees the care of potential patients that
5 are at high risk for return to the hospital. She
6 coordinates and accompanies patients to outside
7 appointments with patients if that's needed at any
8 given time, and that's been well -- very well
9 received by the community physicians because of the
10 clinician-to-clinician collaboration and discussion
11 of the patient and how they're progressing within
12 the facility during their stay with us.

13 There's also collaboration between, like I
14 said, the hospital and the case managers of the
15 hospital and discharge planners and the physicians
16 of the postacute program and the services that we
17 provide within the facility, including proactive
18 communication with patients regarding return to the
19 hospital, medication reconciliation on admission and
20 upon discharge.

21 The collaboration with the hospitals is done
22 on a weekly basis. It's team approach where the
23 hospital partners, as well as the facility partners --
24 those would include our transitional care nurse, the

1 director of nursing at the facility, the therapy
2 team, our discharge planner, case manager,
3 administrator, and some partnership with the care
4 coordination from the hospital's end, as well as the
5 nurse practitioners from the hospital end, too.

6 We sit down and we discuss the patients plan
7 of care. We discuss how the patient is progressing
8 from a clinical standpoint, medical standpoint, as
9 well as from a therapy standpoint and to -- as well
10 as -- I'm sorry -- as well as the discharge planner
11 is there to be able to identify any potential
12 barriers and to also establish resources for home
13 health care equipment needs that the patient will
14 need when they transition to the next level of care,
15 which will be the community.

16 If readmissions do occur within the facility,
17 because we know that sometimes readmissions occur
18 from our facility back to the hospital, but that
19 doesn't necessarily mean that all readmissions are
20 bad readmissions, but there is analysis that's done
21 between the hospitals and the skilled facility. We
22 sit down and we discuss what both sides may have/
23 could have done differently to prevent that
24 readmission, and from that comes possibly

1 reeducation, system and protocol changes on the
2 hospital end, as well as the skilled facility's end,
3 as well.

4 The patients do receive patient education by
5 our nurses, our nurse practitioners that are on
6 staff, our physicians, as well as our registered
7 dieticians to provide diet and healthy lifestyle
8 changes necessary to stabilize the patient within
9 the facility, as well as when they transition home.

10 We follow our patients, as well, once they
11 leave our facility. Our transitional care nurse
12 actually makes a phone call to the patient 24 hours
13 postdischarge on the 7th day of discharge and on the
14 31st day of discharge, as well, to ensure that the
15 patient is still stable within the community, as
16 well as to act as a liaison between the facility,
17 home health care, and the patient to see if there's
18 any additional resources that are needed while the
19 patient is still in the community, and as well as to
20 help with maintaining and preventing patient
21 readmissions to the hospital.

22 This collaborative approach between the
23 hospital and the facility has been proven to reduce
24 the unnecessary readmissions to the hospital and

1 ensure that patients that are discharged to us from
2 the hospital receive quality comprehensive care,
3 achieve their optimal functioning, and provide a
4 seamless transition to the community to continue on
5 with the recovery process.

6 MS. SCHULLO: In closing, thank you for your
7 time and attention this afternoon. We hope we have
8 been able to articulate the Alden difference and how
9 important this development in New Lenox is to all
10 of us. Before I close I want to just add a couple
11 quick statements.

12 We've been looking at the site in New Lenox
13 that is before you for approximately five years, and
14 we have not brought this project before you because
15 there was not a bed need. We've been in contact
16 with the seller and with the Village for a long time
17 now, and the time was right when the bed need came
18 out, and you showed that there was 141 beds needed
19 in the planning area. So we really hope that you'll
20 take that into consideration today when you're
21 considering our project because we're very excited
22 about this project.

23 We ask for your approval of our project. We
24 thank the Board for its consideration and would be

1 pleased to address any questions you may have.

2 CHAIRWOMAN OLSON: Thank you.

3 Questions from Board members?

4 Mr. Sewell.

5 MEMBER SEWELL: Thank you.

6 Help me understand. You sort of dismissed
7 the financial ratios because you argued that, you
8 know, you're a new facility. But these are the
9 projections anyway. So doesn't that mean that
10 there's still something off here in terms of these
11 ratios?

12 I mean, they're 2019 through 2021. So I
13 presume they were calculated based on your projected
14 financial statements, and your demand, and revenue
15 and all that. So I don't know if we can just ignore
16 the financial ratios just because you're new.

17 MR. KNIERY: I get the honors.

18 A couple comments and you've heard these
19 same kind of things before.

20 If you look at the combined ratios, you saw
21 before us a lot of times you have an owner and an
22 operator. ESRDs are a perfect example of that where
23 you never look at a landlord's ratios. This is
24 different.

1 Long-term care is typically different
2 because you have an owner and an operator. Both of
3 them are coapplicants. So a combined -- I guess
4 what I'm saying combined ratios give you a little
5 better picture of the overall total profitability
6 and functionability of the entities. So what you're
7 able to see on page 12 of 19 of the staff report,
8 the ratios are much -- are much better than they are
9 individually.

10 The cushion ratio and today's cash on hand,
11 for instance, are usually the big ones. We have
12 35 days' cash on hand. You need a total of 45.
13 The difference in the cushion ratio is you need
14 three years' coverage. That's a lot of cash
15 especially for long-term care providers.

16 MS. SCHULLO: I just had one. What I was
17 told by the CFO was there is no way we'd ever be
18 positive on a cushion ratio just based on the
19 formula. So that would be negative for almost
20 anybody I think.

21 CHAIRWOMAN OLSON: Mr. Johnson.

22 MEMBER JOHNSON: I think similarly we really
23 didn't address the finding of unnecessary
24 duplication of services. I mean, the fact that

1 there was no timely opposition submitted doesn't
2 really explain away the fact that there's still
3 duplication of services.

4 MR. KNIERY: If I may, Mr. Johnson, one
5 thing you heard from the Village this morning was
6 they have -- I had 24,000 people; they said 26,000
7 and they weren't even including the additional
8 15,000 in the township. But this specific area with
9 24,000 people has no long-term care -- have no
10 long-term care beds.

11 So that's one issue that we have an issue
12 here that's a little bit different. You have to go
13 nearly 10 minutes' travel time to find another
14 provider.

15 You know, we -- there are lot of indicators
16 of need. I can go through all the facilities, but
17 the indicators of need are the bed need, which we
18 know we have. Sufficient population to support the
19 project. Not only do we have the existing New Lenox
20 population, the Village of New Lenox population
21 that has no services, but we also have the State's
22 population projection for the planning area, which
23 is Will County, to show that there's a need, and
24 that's one of the reasons why a projection was found.

1 The issue is the utilization of area
2 facilities. That is the one indicator of need that
3 is negative out of the four, the utilization of area
4 facilities. We're addressing a need that's, again,
5 2018. We're going to be complete after that. So
6 this probably won't be in line for 2, 2 1/2 years.

7 Will the project call for a maldistribution?
8 That's the final criteria for indication of --
9 indicators of need. Maldistribution is typified by
10 there -- there are too many beds in one area. Okay?
11 There are no beds in New Lenox and the issue of --
12 we have a large -- we have 24, 26,000 people and we
13 have a large elderly population within that area
14 just looking -- just looking at New Lenox itself.

15 MR. MOLITOR: I'd like to address, too, the
16 question about are we duplicating services.

17 When I look at our project -- and I'll
18 mention like the Alzheimer's section -- that's a
19 separate distinct building. Nobody else in the area
20 has a separate distinct building exclusively for the
21 Alzheimer's population. So for me that sets us
22 apart from everybody else for one.

23 The other thing that was mentioned before
24 today was we talked about the postacute care

1 services, and I think Tine did a great job of
2 explaining what the difference is is providing
3 postacute care services with the level that we are
4 as it relates to the collaboration with the hospital,
5 the transitional care nurse, the additional meetings.

6 Not every long-term care facility out there
7 participates in this type of program, doesn't
8 dedicate the resources to be able to meet those
9 criteria that the hospitals are currently working
10 under.

11 Can they, in fact, take the same patient?
12 Yes, but it's not about taking the same patient.
13 It's actually what you're doing with that patient
14 and the collaboration to make sure that all the
15 services are provided on a timely basis and are
16 being most efficient in this world of health care
17 today.

18 Not everybody sets themselves up like that.
19 It's just not a reality. A smaller facility might
20 or might not be able to do it, but being on the
21 campus does give you an advantage, too. It really
22 does. And that's primarily for the fact that people
23 view that as a collaboration because we're on the
24 campus with Silver Cross, and there's advantages to

1 that, that is true.

2 But I look at ourselves being different in
3 respect to primarily the way we're taking care of
4 the postacute care services, and we have the
5 separate distinct Alzheimer's/dementia care unit
6 that I feel is new to the whole community in general.

7 MS. SCHULLO: Maybe just one more thing to
8 add. Bob did a great job, and Tine, explaining what
9 we have but besides for the fact that there's no
10 other skilled nursing provider in the village of
11 New Lenox. There already is assisted living in the
12 community and senior housing. They need, they want
13 a place to send their loved ones when they need
14 skilled services.

15 So both on the memory care side and the
16 skilled side I really hope you'll consider our
17 project.

18 CHAIRWOMAN OLSON: Senator.

19 MEMBER DEMUZIO: Just a quick question.

20 We heard all about New Lenox today, it's a
21 growing population I understand, and now we find out
22 that there's not a facility there for this service.

23 Do you have any statistics as to where these
24 individuals go now from New Lenox? Do you have --

1 you're very close -- I mean, that's part of the
2 issue here. You have 48 different facilities,
3 approximately. So that's one of your findings. So
4 where do they go now? Do you have any statistics?
5 How far away do they go?

6 MR. MOLITOR: From everything we looked at,
7 the patients go just about anyplace.

8 MEMBER DEMUZIO: With 48, I mean, you have
9 carte blanche.

10 MR. MOLITOR: You have a number of facilities
11 that have been there a long time, and that's in our
12 whole market all together. Where do people go?
13 Traditionally patients go -- and this is not Bob
14 making up this rule. People typically go the
15 closest to their home. So what we're trying to show
16 everybody is that if New Lenox doesn't have anything
17 within 10 minutes or so, there is an obvious reason
18 why people would go to this facility.

19 MEMBER DEMUZIO: You feel this population of
20 26,000 will be able to keep them there at home
21 rather than go 10 miles or 10 minutes away?

22 MR. MOLITOR: Every community that we go into
23 and we talk to one of the key things is that they --

24 MEMBER DEMUZIO: Their family wants them

1 near home, within five minutes.

2 MR. MOLITOR: They want at home or the
3 family wants them close to home. So that's what
4 we're banking on.

5 MEMBER DEMUZIO: But the duplication of
6 services does create an issue in terms of looking at
7 your findings. Can you give me another reason for
8 me not to think about that?

9 MR. MOLITOR: Well, even though there -- I'm
10 not going to sit and argue the fact that -- skilled
11 care is skilled care. We know that but there's
12 differences in regards to the way it's being done
13 today which we tried to articulate.

14 The bottom line at the end of the day is
15 people are going to go where they feel most
16 comfortable. They're going to look at the
17 environment; they're going to look at the type of
18 people you have working there and how they're treated.

19 We have a really good history in regards to
20 providing quality care. Our latest project we had
21 that you guys approved was Shorewood. We're running
22 87 percent occupancy rate at Shorewood right now,
23 and that was a home that we put in in the same type
24 of area at many different locations.

1 No one -- our competition hasn't complained
2 about the lack of patients in their building. We
3 are just providing a different type of service, and
4 in addition, as you saw this morning, we're
5 following through on our concept because the
6 Shorewood project is also having the memory care
7 right next to it. So that model has worked well,
8 and the community has really enjoyed it.

9 MEMBER DEMUZIO: So New Lenox would have a
10 new facility, and everyone wants a new facility, and
11 everyone wants to stay closer to home. Does that
12 sum it up?

13 MR. MOLITOR: Yes.

14 CHAIRWOMAN OLSON: Other questions or
15 comments?

16 MEMBER JOHNSON: Mr. Constantino, any idea
17 what the average occupancy is for the 38 facilities
18 that are below 90 percent?

19 MR. CONSTANTINO: About 79 percent.

20 MR. KNIERY: Mr. Johnson, if I can also
21 add, if you look at the chart on page 17, Table 10,
22 the first facility, Spring Creek Nursing Rehab, that
23 facility has extremely low utilization, 5.7 percent.
24 You know, it makes you scratch your head what's

1 really going on in this area.

2 If you look online, it used to be Hillcrest
3 Nursing Home, and that facility lost its Federal
4 funding, and there's articles that it's bordering on
5 closing.

6 So there are issues in the service area. I
7 mean, I don't want to beat up -- I think we have a
8 great industry. Everyone is trying to do the best
9 they can. This is a model that addresses a specific
10 area, a specific need that I think works quite well.

11 CHAIRWOMAN OLSON: Other questions or
12 comments?

13 VICE CHAIRMAN HAYES: Thank you, Madam Chair.

14 Can you explain the mortgage and the
15 financing of this project?

16 MS. SCHULLO: This will be a HUD insured loan.

17 VICE CHAIRMAN HAYES: And the term of
18 that note?

19 MS. SCHULLO: It's a 40-year term, the same
20 financing vehicle that we use in the majority of our
21 projects.

22 VICE CHAIRMAN HAYES: And the interest rate
23 is what?

24 MS. SCHULLO: I'd have to look it up. It's

1 about 4 percent.

2 VICE CHAIRMAN HAYES: It says here 4.5 percent.

3 MS. SCHULLO: That sounds right.

4 VICE CHAIRMAN HAYES: The financial ratios,
5 the only thing I would comment on that is they are --
6 with this mortgage on the books, you know, the
7 combined entity, they don't look too good, these
8 ratios there.

9 MR. OURTH: Mr. Hayes, we acknowledge what
10 you're talking about there. One of the things we
11 probably would say is that here we're talking about
12 Alden which has a proven track record for -- how
13 many years, Randi? -- 35 years. All of those
14 projects when going for HUD funding have received
15 the financing. Sometimes HUD takes a lot longer,
16 but the financing is one that there's a long track
17 record and a history of doing a project that's well
18 vetted to make sure -- now maybe they're not as
19 profitable as people would like them to be, but they
20 do have a track record of sustainability and comfort
21 that way despite the individual ratios on this page.

22 So if you're looking at the system, I think
23 you can take broader comfort than you might in
24 looking at one specific facility.

1 VICE CHAIRMAN HAYES: Well, because the HUD
2 is based on mortgage insurance, is that there's
3 either a bank or internal funds that are used to
4 actually make the loan. Do you have a bank that is
5 willing to do this?

6 MR. OURTH: Randi can talk about a
7 long-standing relationship with Cambridge.

8 MS. SCHULLO: This project, we're working
9 with capital funding on this project.

10 VICE CHAIRMAN HAYES: Thank you.

11 MS. SCHULLO: And it's been 45 years that
12 we've been working with HUD on the projects, not
13 35, Joe.

14 CHAIRWOMAN OLSON: Other questions or
15 comments?

16 (No response.)

17 CHAIRWOMAN OLSON: I actually have a
18 question.

19 I'm curious. Do you have any -- I mean, why
20 do you think there were no opposition letters
21 because I somewhat disagree with esteemed colleague.
22 I think the fact that there was no opposition speaks
23 to something.

24 MS. SCHULLO: Truly I feel New Lenox needs a

1 skilled nursing facility. The closest facility is
2 over 5 miles away, and I think the fact that we are
3 not next door to another skilled nursing provider
4 says a lot. As I said earlier, your Board showed a
5 need of about 141 beds, and we waited for the
6 opportunity to appear before you now that the bed
7 need is there, and having no other skilled nursing
8 provider in the area, that really says a lot.

9 CHAIRWOMAN OLSON: So let me ask you this
10 because -- I sort of have an issue with this whole
11 dead bed thing, and I think it's something that the
12 industry created for themselves and has to live
13 with. So I have little sympathy when people come up
14 here and say it's over 80 percent occupancy but
15 really that's all -- because that's something you
16 created yourselves.

17 But do you think that that's playing a part
18 into why? Because many of these are pretty close.
19 If you go down the list, a lot of them are pretty
20 close to the 90 percent threshold. And, again, like
21 I said, I don't have much sympathy that you as an
22 industry created that whole dead bed mess but is
23 that partially --

24 MR. MOLITOR: I'll be honest with you, yeah,

1 I think you're right on target. Facilities do make
2 a choice as to where their occupancy should be.

3 If you have a facility -- one of the things
4 that we try to do or at least our company tries to
5 do is that we want to deliver the best care possible
6 every single day. Sometimes that's not maximizing
7 your building; it's not saying in your 200-bed
8 building put 200 people in your building. If you're
9 sitting in a position where you can meet your
10 financial obligations and everything is going well,
11 you might not look at it and say, "I need to be at
12 90 percent occupancy every day."

13 CHAIRWOMAN OLSON: So why don't you give up
14 the beds? It's a money thing; right?

15 MR. MOLITOR: Well, that relates back to the
16 mortgage. If you buy a facility, and you buy a
17 facility for 316 beds, then that's what it's valued
18 at. How do you go back to your lender and say,
19 "Well, I only have 200 today"? It devalues the
20 property in a lot of people's minds. That's
21 something we need to continue to debate on.

22 I would like to say one other thing. You
23 asked the question why the other operators might not
24 be complaining so much or didn't come up to complain.

1 This is an area, too, that has multiple
2 hospitals. The locations are not depending upon one
3 hospital, Silver Cross. There's many hospitals out
4 there. If we were in New Lenox, we would also be
5 looking to get patients from other locations.

6 I think when I look at the demographics of
7 this, some of our competitors are in closer
8 proximity to other hospital systems where we're not
9 going to be pulling a lot of patients, so they're not
10 necessarily worried about their occupancy. That's
11 how I look at it.

12 CHAIRWOMAN OLSON: Other questions or
13 comments?

14 (No response.)

15 CHAIRWOMAN OLSON: Seeing none, I'd ask for
16 a roll call vote on 15-051, Alden Estates-Courts of
17 New Lenox in New Lenox.

18 MR. ROATE: Thank you, Madam Chair. Motion
19 made by Mr. Hayes, seconded by Mr. Sewell.

20 Senator Burzynski.

21 MEMBER BURZYNSKI: Here we go again. I'm
22 going to vote no based on the fact that we had
23 three findings from the State board staff and in an
24 effort to be consistent. Thank you.

1 MR. ROATE: Thank you.

2 Senator Demuzio.

3 MEMBER DEMUZIO: I have some real concerns
4 here just for the mere fact that you're so close,
5 there's 48 different facilities around.

6 Having said that, I also know that when you
7 go into a new community like New Lenox, they're
8 probably going to be thrilled to death. So I'm
9 going to go ahead and vote yes just for the mere
10 fact that if it wasn't for New Lenox, I probably
11 wouldn't be doing so.

12 MR. ROATE: Thank you.

13 Justice Greiman.

14 MEMBER GREIMAN: I'm taking into
15 consideration the responses of the panel to issues
16 that I thought were somewhat important, and so I'm
17 going to vote yes.

18 MR. ROATE: Thank you.

19 Mr. Hayes.

20 VICE CHAIRMAN HAYES: I'm going to vote no
21 based on the State agency report and unnecessary
22 duplication of service and service accessibility.

23 MR. ROATE: Thank you.

24 Mr. Johnson.

1 MEMBER JOHNSON: I'm also going to vote no
2 based on the State agency report.

3 MR. ROATE: Thank you.

4 Mr. McGlasson.

5 MEMBER MCGLASSON: I'm going to vote yes
6 because I think the case was made for putting a
7 facility in New Lenox.

8 MR. ROATE: Thank you.

9 Mr. Sewell.

10 MEMBER SEWELL: I'm going to vote no.
11 There's probably not a more classic conflict between
12 institutional planning, which I think has been good
13 and the innovations with care of Alzheimer's
14 patients, and planning for the region. Our job is
15 planning for the region.

16 MR. ROATE: Thank you, sir.

17 Madam Chair.

18 CHAIRWOMAN OLSON: I'm actually going to
19 vote yes. I understand there are three negative
20 findings, but I agree with Senator Demuzio that it's
21 important for a community to have a nursing home of
22 their own, and I also think the fact that there was
23 no opposition by the other area providers to this
24 project speaks volumes about, even though there is a

1 negative finding on that, them not being concerned
2 about maldistribution. So I'm going to vote yes.

3 MR. ROATE: Thank you, Madam Chair.

4 That make 4 votes in the positive, 4 votes
5 in the negative.

6 CHAIRWOMAN OLSON: The motion fails.

7 MR. MORADO: You're going to be receiving an
8 intent to deny notification from the Board, and
9 you're going to have an opportunity to come back and
10 appear before the Board and submit additional
11 information if you so desire.

12 CHAIRWOMAN OLSON: Thank you.

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CHAIRWOMAN OLSON: Applications subsequent to intent to deny, there are none.

There is no other business.

Rules development. Jeannie.

MS. MITCHELL: We have two rules that we are going to seek to repeal. They're both obsolete.

One has to do with area health planning organizations which we have not used for years, and the other one has to do with an appropriateness review which was conducted because of the area health planning organization.

So I believe those two rules were e-mailed to you, and we're going to seek to have them repealed.

That's it.

CHAIRWOMAN OLSON: So that's basically housekeeping?

MS. MITCHELL: Right.

CHAIRWOMAN OLSON: Next order of business is old business.

The employee handbook, Juan.

MR. MORADO: We sent out the employee handbook via e-mail and mail a couple weeks ago to the Board members, and I had an opportunity to speak

1 with Member Galassie who is not here today, and he
2 had some notes and some comments about the employee
3 handbook. Mainly it was about things that we
4 probably can't do. He was interested in perhaps
5 providing additional benefits to staff that may not
6 be necessarily allowed because of our status as
7 State employees with regard to pension pickups.

8 But outside of that he was very complimentary,
9 and if you have any questions about the handbook,
10 again, we kind of took the Department of Public
11 Health's handbook, mirrored what made sense for the
12 Board. We removed a lot of language that had to do
13 with collective bargaining because the employees who
14 work for the actual Board, myself, Courtney,
15 Jeannie, and Nelson are not members of a bargaining
16 unit. So we removed that.

17 The other item that I changed had to do with
18 progressive discipline under the Department of
19 Public Health progressive discipline plan. You can
20 have, I believe it was up to 12 excused absences
21 before you could be terminated. That just seemed to
22 be like a bit too many. So I reduced ours to five,
23 which also seems like quite a bit, but I thought it
24 was better than 12.

1 Outside of that, those are the only real
2 major changes I made. I'm not sure if anyone has
3 any questions about it.

4 CHAIRWOMAN OLSON: Richard.

5 MEMBER SEWELL: Do we have any employees
6 that are nonexempt from the overtime provisions of
7 the Fair Labor Standards Act? I'm getting at
8 overtime pay. Or is everybody exempt so it doesn't
9 apply?

10 MR. MORADO: So all of the Board staff are
11 exempt employees. One of the things that we did try
12 to clarify within this handbook is something called
13 EET, which is earned equivalent time. Earned
14 equivalent time is getting at that overtime
15 question, Member Sewell. So there are instances
16 where perhaps Board staff has to be at a public
17 hearing from 3:30 to maybe 9:30 at night.

18 MEMBER SEWELL: That's what made me think
19 about that.

20 MR. MORADO: They might be compensated
21 instead of monetarily with earned equivalent time.
22 So that time would be able to be used as like PTO or
23 vacation time. It's comp time. And although it is
24 available now, we are just solidifying it, if you

1 will, in our handbook.

2 CHAIRWOMAN OLSON: Other questions?

3 (No response.)

4 CHAIRWOMAN OLSON: Do we need a motion?

5 MR. MORADO: Yes, please.

6 CHAIRWOMAN OLSON: I'd like to ask for a
7 motion to approve the employee -- the HFSRB employee
8 handbook as amended in December 2015.

9 MEMBER DEMUZIO: Motion.

10 CHAIRWOMAN OLSON: Motion by Demuzio. Do we
11 have a second?

12 VICE CHAIRMAN HAYES: Second.

13 CHAIRWOMAN OLSON: Second by Hayes. All
14 those in favor say aye.

15 (Ayes heard.)

16 CHAIRWOMAN OLSON: Opposed, like sign.

17 (No response.)

18 CHAIRWOMAN OLSON: The motion passes and it
19 is approved.

20 Under new business we have some data
21 revisions. Juan, do you want read them -- oh,
22 Mike -- I'm sorry.

23 MR. CONSTANTINO: We received these
24 two revisions to the data. Rather than do a

1 declaratory report, we put them on the agenda pretty
2 much to let you know that they've been submitted and
3 we're correcting the data.

4 CHAIRWOMAN OLSON: You don't need a motion
5 or anything?

6 MR. MORADO: No.

7 CHAIRWOMAN OLSON: Public policy and
8 participation guidelines. Courtney just handed out
9 the new revised public participation guidelines.
10 I'll let her speak on the changes that were made.

11 MS. AVERY: They were very minor changes.
12 One that you had that was e-mailed was a red-lined
13 copy and then the new copy.

14 So what we removed was that public comment
15 for each speaker is limited to testimony for one
16 project or issue. It was brought to my attention
17 that some people may have an interest in more than
18 one project, so we removed that.

19 We left in that speakers may not read
20 testimony on behalf of someone who is not present at
21 the Board meeting.

22 The other was pertaining to individuals from
23 the same organization, must present together when
24 providing testimony regarding the same project. So

1 we removed that because people were not doing that,
2 so it was unnecessary to have it in there.

3 Speakers cannot repeat comments already made
4 at a public hearing or already submitted in writing
5 form to the Board. We just had a really hard time
6 tracking it, and we didn't know if those comments
7 were being repeated, if they were sitting there,
8 there was no way to track it, and it could be
9 disputed, so that was removed.

10 Those were the two main points, one to
11 revise the actual form. We don't require a
12 signature to sign in; you can just submit it without
13 the signature. I think we will document people that
14 are at the table that are providing public comment
15 through the sign-in for the court reporter and then
16 their testimony.

17 And that was it -- oh, one other thing.

18 MEMBER GREIMAN: Why can't they read something
19 written by someone else who isn't there?

20 CHAIRWOMAN OLSON: They can. We took
21 that out.

22 MS. AVERY: They can't.

23 MEMBER GREIMAN: It's in there.

24 MS. AVERY: Speakers may not read testimony.

1 MEMBER GREIMAN: Why not?

2 MR. MORADO: Judge, we used to get a lot of
3 folks who would send letters on behalf of other
4 people who they may or may not have had an interest
5 in the project, but it seemed to be we were getting
6 a lot of folks that were coming in just reading
7 letters when there's a written comment process that
8 would allow them to -- -

9 MEMBER GREIMAN: On the other hand, they may
10 be quoting what a doctor says about some health
11 issue we're dealing with.

12 MR. MORADO: One exception we make is for
13 folks who may not necessarily be able to speak for
14 whatever reason. They do show up at these meetings,
15 and if somebody wants to read on their behalf,
16 that's fine. The issue would be folks would maybe
17 didn't take advantage of the written comment process
18 that they could have and just want to have somebody
19 come here and read it.

20 MS. AVERY: So there is an opportunity to
21 submit comments on a project prior to the public
22 participation at the Board meeting, and that's
23 through the written comment period.

24 Do you want us to look at that again? Do

1 you have suggestions? Do we want to remove it?

2 CHAIRWOMAN OLSON: I think part of the issue
3 was trying somehow not have public participation
4 last for the entire morning or three-quarters of the
5 day, especially in light of the fact that there's
6 many other opportunities for people to be providing
7 public comment or written comment on any one of the
8 projects.

9 So I guess this was an attempt to try to be
10 concise about what we're going to allow at the
11 meetings. Otherwise, we could have potentially a
12 health system have 100 letters signed -- allegedly
13 signed by 100 different people. We know we see that
14 in our packets a lot of times that somebody will
15 send out a form letter to anybody in the entire
16 community and ask them to sign it and send it back
17 in as part of public testimony.

18 Well, if we allow that at public participation,
19 we could potentially have a filibuster if somebody
20 is just going to read 100 letters on behalf of
21 100 citizens in Bloomington, Illinois, or Normal.
22 We could look at that again if you believe that's
23 going to limit people's opportunity to speak. I see
24 what you're saying; a doctor can't come in here and

1 sit here all day.

2 Would you like us to look at that again,
3 Justice?

4 MEMBER GREIMAN: No.

5 CHAIRWOMAN OLSON: Any other questions or
6 comments with regard to that?

7 (No response.)

8 CHAIRWOMAN OLSON: Legislative update.

9 MS. AVERY: Okay. I also passed out earlier
10 the legislation for this session as affecting the
11 Board. I'll just go through them really quickly.

12 We have our initiatives, which are HB4517,
13 4518, 4519, and 4520. Those all have to do with
14 the -- of course, the Planning Act. And what we're
15 asking -- we've already submitted these. Because of
16 the timeline we had to submit them, but if there's
17 some reason why you would want them to be withdrawn,
18 we'll do so.

19 First of all, 47 -- 4517 amends the Act and
20 removes the -- repeals the language regarding the
21 Center for Comprehensive Health Planning.

22 18 is more of a cleanup. One is to clarify
23 that State-owned facilities not licensed by the
24 Department of Public Health must seek a CON to

1 discontinue.

2 We had an issue where there was a State-
3 owned facility that is not licensed -- and I'm not
4 sure why -- but not licensed by Public Health that
5 did not feel like they fell under the Health
6 Facilities Planning Act, removes the operational
7 support to HFSRB and adds the language that that
8 operational support will be provided in accordance
9 with an interagency agreement.

10 And for consistency with similar sections
11 that require final completion reports we're asking
12 for a discontinuation of a facility or service, that
13 they can do the same, and, if not, they'll be imposed
14 a fine for noncompliance. Again, for consistency at
15 public hearings for discontinuation should be given
16 a reasonable opportunity to present their position
17 orally or in writing just clarifying it, and it
18 removes the language pertaining to certificates of
19 recognition which we no longer do.

20 We also removed the language pertaining to
21 SMHRA, but this is going to be amended because it
22 was removed from one section and put in another, and
23 we weren't aware of that.

24 4519 we're asking for an extension of the

1 sunset date for December 31st, 2029, rather than
2 December 2019, and 4520 is a shell bill just in case
3 we have something else that we need in the future.

4 MEMBER SEWELL: Courtney.

5 MS. AVERY: Yes.

6 MEMBER SEWELL: While we're on that page, I
7 want to go on record as opposing 4517 and 4519.

8 4517 because even though we've gotten no
9 traction on implementing the Comprehensive Center
10 for Health Planning, certificate of need conceptually
11 is a tool for planning. The idea is that you have a
12 plan, and then you make decisions in certificate of
13 need in support of that plan. To take planning out
14 of the concept I think is a step backwards. So I
15 oppose that.

16 And I also oppose having any sunset on the
17 law. At the time that we don't need certificate of
18 need we could just have the legislature, governor
19 repeal it. We don't need to have a date. So I
20 don't get why we would support having a date in
21 anything.

22 MS. AVERY: Because we have a date now, and
23 we kind of brainstormed and figured it would be
24 easier to have it extended rather than to eliminate

1 it just looking at the --

2 MEMBER SEWELL: I'm not suggesting that this
3 Board do this. I just want to be on record as
4 opposing both of these.

5 MS. AVERY: Okay. And let me go back to the
6 center. Again, one of our thoughts there is that
7 this center costs us -- well five, six, seven years
8 ago it cost us about a million. That money was
9 never expended, but it's been appropriated every
10 year, and it's appropriated through the Department
11 of Public Health, and the Department of Public
12 Health will have total control over the center, from
13 the employees, to the money, and everything when it
14 was coming out of the planning fund.

15 And bits and pieces of this we already do.
16 And even if the center came up with a health plan
17 for the State, there's no incentive for facilities
18 to go and build in the areas where we know there's
19 already a need. We know where the need is, but,
20 again, there are no tax breaks, there's no "We'll
21 build a hospital for you so you can go and provide
22 services," and I'm just using Cairo as an example.
23 But we already know what the need is, so we have a
24 health plan, and it just seemed like the center was

1 a duplication of it, and it was costing us upward of
2 a million dollars that we have no control over.

3 So that's why we were asking to remove it.

4 CHAIRWOMAN OLSON: If you remember, the IDPH
5 did a protection on that, and I think it was by
6 2014 -- no, it was by -- I don't know, within a very
7 few number of years it was going to be bankrupt. It
8 was going to bankrupt this Board and not be
9 sustainable based on the revenue that it required to
10 keep it sustainable.

11 And I actually had a very candid
12 conversation with Dr. Shah about this, and he
13 initially didn't understand any reason for having
14 this center either because he said it's basically
15 the same kind of due diligence that any kind of a
16 health system is going to do when they decide
17 whether to build. And one of Courtney's comments,
18 just because we say the center does all this
19 research doesn't mean anybody is going to build a
20 hospital in Cairo or there's any incentive for them
21 to do that anyway.

22 MEMBER SEWELL: We need to talk about this
23 later. I think there's a difference between IDPH
24 misbehaving and the conceptual relationship between

1 CON and the regulatory issue and the rawer issue of
2 planning for health. But we'll talk about it later.

3 CHAIRWOMAN OLSON: All right. I just want
4 to make sure we're on the same page.

5 MEMBER GREIMAN: Madam Chair.

6 CHAIRWOMAN OLSON: Yes.

7 MEMBER GREIMAN: What's the status of --
8 what is it -- 49?

9 MS. AVERY: Oh, I'm going to get to that.

10 CHAIRWOMAN OLSON: We're going to talk about
11 that one.

12 MEMBER GREIMAN: Okay.

13 MS. AVERY: Two more and I'll just go
14 through this really quickly.

15 House Bill 4370 is an initiative of -- gosh,
16 I forgot the name of it -- Representative William
17 Davis and Don Johnson, and I forget who he
18 represents, like someone in trades. I apologize for
19 that; I'm drawing a blank. But this is just
20 amending the Act to say that the Board will, for
21 lack of a better term, assist in collecting data
22 that pertains to capital expenditures for health
23 care facilities.

24 And I know that he is in discussion with IHA

1 on what this should look like as far as procurement
2 goes and who should be covered under this, and I
3 haven't gotten an update from the him at this point,
4 but he asked that we support it, and I told him I
5 would give him an answer after today's Board
6 meeting.

7 So if you guys can just shoot me an e-mail
8 to let me know after you've had some time or if you
9 want to say overall, yeah, we can support it. It's
10 not anything that would cost the Board. We won't
11 have to do anything but collect it on our current
12 survey and it just adds a question, and I checked
13 with IDPH staff and Nelson and that's easy to do.
14 We don't have to use the data for our applications.
15 It will not be included in State Board staff
16 reports. We would just collect the data, and it
17 will be floating out there, and those two -- that
18 organization that Don runs can do whatever they need
19 to do with it.

20 MEMBER SEWELL: Are you talking about 4370?

21 MS. AVERY: 4370.

22 MEMBER SEWELL: For the record, I have a
23 serious conflict of interest on this and won't be
24 saying anything on that.

1 MS. AVERY: House Bill 4964, I'm not sure if
2 that's going to be called or not. I've had a
3 preliminary agreement that it will not, but still
4 you never know. And that has to do with the
5 discontinuation of category of service that it be
6 published five consecutive days rather than one or
7 three consecutive days in the newspaper of general
8 circulation, and that when it's closed that there
9 must be a public hearing held rather than merely
10 afford an opportunity to request a hearing, and that
11 an application to discontinue a category of service
12 when it's complete, the State Board must hold a
13 public hearing before an exception is issued.

14 So what this representative is trying to get
15 at, I don't think this is the way to do it. And
16 I've had, like I said, preliminary discussion with
17 her, and she's not sure if she wants to move it
18 forth. If she does move it forward, she'll give us
19 a call and let us know what's going on.

20 I did express to her my concern about the
21 five consecutive days in the general circulation
22 because it costs us a lot of money, and if we could
23 have alternative ways to post that rather than in
24 the newspaper for five days.

1 4982 is the act that -- this legislation
2 sponsored by David Harris and will repeal the
3 Illinois Health Facilities Planning Act and
4 abolished the Health Facilities and Services Review
5 Board, and all I can say is that I recommend that
6 you oppose it, and we'll go forth from there.

7 MEMBER SEWELL: Where is this coming from?

8 MS. AVERY: This, unfortunately, is coming
9 from the Department of Public Health, and I think
10 Kathy shared with you a couple of meetings ago her
11 discussion with Director Shah. So I don't know if
12 you want to share anything else.

13 MEMBER SEWELL: Has the chairperson talked
14 to Director Shah?

15 MS. AVERY: Yes.

16 CHAIRWOMAN OLSON: I have. I have and he
17 welcomes spirited discussion on the issue. He kept
18 telling me he was an academic and he doesn't believe
19 in -- doesn't think the CON process is necessary.

20 MEMBER SEWELL: Usually, economists typically
21 don't know anything about health economics.

22 CHAIRWOMAN OLSON: It was a nice pleasant
23 discussion, but we're on different sides of the
24 issue. So I will definitely oppose that.

1 MEMBER GREIMAN: Has the bill been assigned
2 to --

3 MS. AVERY: No. The bill is still in rules,
4 and I've been working pretty hard to make sure it --

5 MEMBER GREIMAN: Stays there.

6 MS. MITCHELL: And, Member Sewell, although
7 the bill does -- would get rid of the CON program,
8 it would keep the Center for Comprehensive Health
9 Planning.

10 CHAIRWOMAN OLSON: Then they've got no money
11 to pay for it.

12 MS. AVERY: Well, I don't know because Bill
13 and I had a discussion about that, and I said,
14 "Doesn't it leave the center in?"

15 But, Bill, you didn't think it leaves the
16 center in?

17 MR. DART: The center is not deleted in
18 that. There's a drafting error because it was
19 certainly intended that that would be removed.
20 We've had some problems with our LRB attorney that's
21 been working those proposals.

22 MS. MITCHELL: And that could be because the
23 center is actually in a different act. The creation
24 of the center is not in the Planning Act, so that's

1 probably where the oversight is.

2 MEMBER SEWELL: Why do all these people want
3 us to not get reimbursed for expenses?

4 MS. AVERY: We don't know exactly where that's
5 coming from. I can't really get an answer. I've
6 contacted Cassidy, Flowers, Wallace, Harris, a lot
7 of democrats, and I don't think they know the effect
8 it's having. I think what they're trying to do is
9 eliminate the compensation, or if you're compensated
10 you don't get reimbursed.

11 MS. MITCHELL: I think they're just trying
12 to -- I think they're trying to save money or at
13 least appear as if that's what they're attempting to
14 do. Because we're not the only board or agency
15 affected by this. Other boards are losing -- some
16 boards that are compensated are losing compensation,
17 and some boards that aren't, they're losing expenses
18 being reimbursed.

19 MS. AVERY: So still waiting to hear about
20 that one but, again, we'll oppose it.

21 CHAIRWOMAN OLSON: When I talked to my
22 senator about that, his opinion was that somebody
23 was looking for a sound bite. They're trying to say
24 they're saving money and they need something to put

1 in there. Because I told him I think that's a real
2 kick in the teeth when we don't get paid anything to
3 take away our 58 bucks that we get for driving here
4 or if we've got to drive to Springfield to stay
5 overnight to make us pay for our room the night
6 before. So we'll obviously oppose that.

7 MS. AVERY: That's it.

8 CHAIRWOMAN OLSON: Next we have the fiscal
9 update.

10 MS. AVERY: We don't have a traditional
11 report right now because of the lack of the payment
12 of bills. So we haven't really spent any money.

13 Kim Palmer did give me some numbers, and
14 she's on the bill staff that works with
15 appropriations, and bills, and accounts, and all of
16 that. So far just for salaries an appropriation
17 that -- well, she can't run a voucher but we have
18 about -- I don't think this is right -- no, this is
19 for operational expenses. About 31,000 on IDPH's
20 side for support is appropriations and about 61,000
21 on our side, HFSRB for appropriations.

22 But we are getting paid. It looks like year
23 to date we're at about a \$1,126,000 for everything,
24 the initial calculated exemptions from net renewals,

1 that's what we've had come in from July to January,
2 which is down drastically. But, again, we don't
3 have the traditional reports because they're not
4 being paid by the comptroller, which is how she runs
5 her reports in the accounting system.

6 But the staff is getting paid. We're not
7 getting reimbursed right now for our travel expenses,
8 but the vouchers are being processed and just
9 waiting on a budget and then the appropriations to
10 be authorized.

11 CHAIRWOMAN OLSON: Don't be surprised if we
12 get an e-mail that we have to bring a sack lunch
13 next month because we haven't paid Bolingbrook since
14 July, and we appreciate the fact that they've been
15 very accommodating. So you might have to bring your
16 Lunchable next month.

17 Are we sure we're having a meeting next
18 month?

19 MS. AVERY: George, where are we?

20 MR. ROATE: I want to say the March 29th
21 meeting is in Bolingbrook.

22 MS. AVERY: It's Bolingbrook. But, I mean,
23 as far as applications it looks like we'll have a
24 meeting.

1 MR. ROATE: Currently I want to say I think
2 we have six or seven.

3 MS. AVERY: Oh, so we're not sure.

4 MR. CONSTANTINO: Well, that Chicago Heights
5 project is scheduled for next month.

6 MS. AVERY: Yes. So we will be meeting next
7 month. We will meet next month.

8 MEMBER GREIMAN: Is the University of
9 Chicago coming up next month, too?

10 MS. AVERY: We just received that application
11 today, and, of course, George and Mike haven't had a
12 chance to review it, to go through the process. So
13 hopefully it will be posted sometime next week
14 deemed complete, the University of Chicago for the
15 trauma center.

16 MR. ROATE: The cutoff for March has already
17 occurred, so it won't --

18 MS. AVERY: No, he hasn't received it yet.
19 No, it won't be heard in March. It won't be heard
20 in March because we just received it today.

21 CHAIRWOMAN OLSON: May I have a motion to
22 adjourn?

23 VICE CHAIRMAN HAYES: So moved.

24 MEMBER SEWELL: Second.

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CHAIRWOMAN OLSON: All those in favor.
(Ayes heard.)
CHAIRWOMAN OLSON: Meeting is adjourned.
(Off the record at 3:44 p.m.)

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CERTIFICATE OF SHORTHAND REPORTER

I, Paula M. Quetsch, Certified Shorthand Reporter No. 084-003733, CSR, and a Notary Public in and for the County of Kane, State of Illinois, the officer before whom the foregoing proceedings were taken, do certify that the foregoing transcript is a true and correct record of the proceedings, that said proceedings were taken by me stenographically and thereafter reduced to typewriting under my supervision, and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 25th day of February, 2016.

My commission expires: October 16, 2017



Notary Public in and for the
State of Illinois

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