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Transcript of Open Session - Meeting

Date: February 25, 2020

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 60490

Tuesday, February 25, 2020

9:13 a.m.

BOARD MEMBERS PRESENT:

DEBRA SAVAGE, Chairwoman

SENATOR DEANNA DEMUZIO

SANDRA MARTELL

LINDA RAY MURRAY

KENT SLATER

Job No. 257110

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Reported by: Paula Quetsch, CSR, RPR

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1 EX OFFICIO MEMBERS PRESENT:

2 DEBRA BRYARS, Department of Public Health

3

4

5 ALSO PRESENT:

6 COURTNEY AVERY, Administrator

7 MICHAEL CONSTANTINO, IDPH Staff

8 ANN GUILD, Compliance Manager

9 RUKHAYA ALIKHAN, General Counsel

10 GEORGE ROATE, IDPH Staff

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P R O C E E D I N G S

CHAIRWOMAN SAVAGE: Good morning. We have a full agenda today and we appreciate everyone for being here.

Mr. Roate, would you please call the roll.

MR. ROATE: Yes, ma'am.

Senator Demuzio.

MEMBER DEMUZIO: Present.

MR. ROATE: Dr. Martell.

MEMBER MARTELL: Present.

MR. ROATE: Dr. Murray.

MEMBER MURRAY: Present.

MR. ROATE: Mr. Slater.

MEMBER SLATER: Present.

MR. ROATE: Chairwoman Savage.

CHAIRWOMAN SAVAGE: Here, present.

MR. ROATE: Five in attendance.

MS. AVERY: Good morning. Again, thank you for being here. We will be remiss if the Board didn't acknowledge the contributions given to us through Mr. Charles Foley, who unfortunately has died. So we just wanted to take a moment to recognize him and to thank him publicly for all that he's done to advocate for the Board, Public

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1 Health, and area long-term care facilities,
2 hospitals, ASTCs. He was just a great, great
3 person, and he will be sorely missed.

4 Thank you.

5 CHAIRWOMAN SAVAGE: May I have a motion to
6 go into closed session pursuant to Section 2(c)(1),
7 2(c)(5), 2(c)(11), and 2(c)(21) of the Open
8 Meetings Act?

9 MEMBER DEMUZIO: Motion.

10 CHAIRWOMAN SAVAGE: May I have a second.

11 MEMBER MURRAY: Second.

12 CHAIRWOMAN SAVAGE: Thank you.

13 So if everyone can step out, approximately
14 15 minutes.

15 (At 9:17 a.m. the Board adjourned into
16 executive session. Open session proceedings
17 resumed at 9:44 a.m. as follows:)

18 CHAIRWOMAN SAVAGE: We are back in
19 session. Thank you so much.

20 MEMBER SLATER: I think you need a motion.

21 CHAIRWOMAN SAVAGE: Yes, may I have a
22 motion to approve the February 25th, 2020, agenda?

23 MEMBER SLATER: I move we return to open
24 session.

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1 CHAIRWOMAN SAVAGE: A motion to return to
2 open session. All in favor, aye.

3 (Ayes heard.)

4 CHAIRWOMAN SAVAGE: And now a motion to
5 approve the February 25th, 2020, meeting agenda.

6 MEMBER MURRAY: So moved.

7 CHAIRWOMAN SAVAGE: Second.

8 MEMBER MARTELL: Second.

9 CHAIRWOMAN SAVAGE: All in favor, aye.

10 (Ayes heard.)

11 CHAIRWOMAN SAVAGE: Okay. The agenda is
12 approved.

13 May I now have a motion to approve the
14 December 10th, 2019, meeting transcript?

15 MEMBER MURRAY: So moved.

16 CHAIRWOMAN SAVAGE: Second.

17 MEMBER MARTELL: Second.

18 CHAIRWOMAN SAVAGE: All in favor, aye.

19 (Ayes heard.)

20 CHAIRWOMAN SAVAGE: Okay. Those are
21 approved.

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1 CHAIRWOMAN SAVAGE: May I have a motion
2 to refer to legal counsel for Palos Hills Surgical
3 Center, Project 17-041 and Cook County
4 John H. Stroger Hospital, Project 16-030?

5 MEMBER SLATER: I so move.

6 MEMBER MURRAY: Second.

7 CHAIRWOMAN SAVAGE: Roll call vote,
8 Mr. Roate.

9 MR. ROATE: Thank you, Madam Chairwoman.

10 Motion made by Mr. Slater; seconded by
11 Dr. Murray.

12 Senator Demuzio.

13 MEMBER DEMUZIO: Yes.

14 MR. ROATE: Dr. Martell.

15 MEMBER MARTELL: Yes.

16 MR. ROATE: Dr. Murray.

17 MEMBER MURRAY: Yes.

18 MR. ROATE: Mr. Slater.

19 MEMBER SLATER: Yes.

20 MR. ROATE: Chairwoman Savage.

21 CHAIRWOMAN SAVAGE: Yes.

22 MR. ROATE: 5 votes in the affirmative.

23 CHAIRWOMAN SAVAGE: The motion is passed.

24 - - -

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1 CHAIRWOMAN SAVAGE: Now may I have a
2 motion to approve the settlement for Swedish
3 American Hospital, Project 17-030.

4 MEMBER DEMUZIO: Motion.

5 CHAIRWOMAN SAVAGE: Second.

6 MEMBER MURRAY: Second.

7 CHAIRWOMAN SAVAGE: All in favor -- or a
8 roll call vote, Mr. Roate.

9 MR. ROATE: Thank you, Madam Chair.

10 Motion made by Senator Demuzio; seconded
11 by Ms. Martell -- Dr. Martell -- oh, Dr. Murray.
12 Senator Demuzio.

13 MEMBER DEMUZIO: Yes.

14 MR. ROATE: Dr. Martell.

15 MEMBER MARTELL: Yes.

16 MR. ROATE: Dr. Murray.

17 MEMBER MURRAY: Yes.

18 MR. ROATE: Mr. Slater.

19 MEMBER SLATER: Yes.

20 MR. ROATE: Chairwoman Savage.

21 CHAIRWOMAN SAVAGE: Yes.

22 MR. ROATE: 5 votes in the affirmative.

23 CHAIRWOMAN SAVAGE: The motion has passed.

24 - - -

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1 CHAIRWOMAN SAVAGE: So I ask speakers --
2 we're going into public participation. So I ask
3 speakers please adhere to our two-minute rule and
4 conclude comments when Mr. Roate signals. I would
5 also ask if you have any written comments that you
6 hand them over to Mike when you're done reading them.

7 So, Ms. Guild, if you would please proceed.

8 MS. GUILD: There are seven people who are
9 registered for public participation. So I'm going
10 to ask you all to come up.

11 The first project is Encompass Health
12 Rehabilitation Hospital of Libertyville, Barbara
13 Martin.

14 The next project is Metroeast Endoscopic
15 Surgery Center, Mark Freeland.

16 There are several on this project. It's
17 Dialysis Care Center of Rockford. I have Tracy
18 Harris, Jacqueline Trejo -- and I'm sorry if I
19 butcher your names -- Blanca Vigil Mendoza.

20 Next project is Javon Bea Hospital,
21 Ken Ripstein.

22 And final public participation registrant
23 is for Burr Ridge Birth Center, Robin Ross.

24 So, Barb, you can start anytime.

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1 MS. MARTIN: Good morning, Members of the
2 Board. My name is Barb Martin, and I'm the former
3 CEO of Vista Health System in Lake County. I most
4 recently worked with Encompass Health in their
5 evaluation of their comprehensive rehab needs in
6 the community and assisted them with a grassroots
7 campaign to connect with many providers who
8 eventually wrote both letters of support for this
9 project and have committed to making referrals to
10 the hospital.

11 I have worked in the healthcare industry
12 for 35 years, and specifically 15 years of those
13 have been and are up in Lake County. I've
14 witnessed firsthand that comprehensive rehab care
15 has disappeared in HSA 8 over the years. After I
16 left Vista Health System, the last rehab beds in
17 Lake County were discontinued by Vista in early
18 2018. If you look back at the historical data of
19 the Health Facilities Planning Board, there has been
20 a trend in recent years of acute care hospitals
21 discontinuing their rehab beds.

22 Allow me to provide you some context. The
23 type of intensive rehab care that Encompass offers
24 at their facilities is highly specialized, and

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1 acute care hospitals either do not have the
2 expertise or are unable to dedicate the necessary
3 resources to provide this type of care.

4 I set out months ago to assist Encompass
5 with an effort to meet with community leaders,
6 elected officials, and doctors in the community to
7 educate them on this application and to see if
8 they would be interested in supporting the project
9 and referring patients to the new proposed hospital.

10 The response was absolutely overwhelming.
11 In meeting with doctors in the community, the
12 stories were all the same. Because these services
13 are not available in this area, the patients who
14 have suffered some of the most extreme injuries
15 have been forced to travel as far north as
16 Milwaukee, Wisconsin, and as far south as downtown
17 Chicago to receive this care. For those of you
18 who have ever driven from the far north suburbs to
19 Chicago, you can only imagine how incredibly
20 difficult it is on families who need to be part of
21 their care.

22 Consistent with your rules we were able to
23 turn in documented referral letters that would
24 account for nearly every bed in the new hospital.

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1 What's most amazing is that these referrals are
2 coming from individual community physicians who
3 justified nearly every bed we are proposing.

4 I feel very confident that if the Board
5 approves this project, it will be at full
6 utilization within a very short period of time.
7 As a healthcare leader in the community, I am
8 confident that there's a greater need than
9 reflected in the referral letters, and that is why
10 I fully support the approval of Encompass Health
11 Rehabilitation Hospital Libertyville and ask that
12 you do the same.

13 Thank you for your time.

14 MS. GUILD: Thank you. Next speaker, Mark
15 Freeland, Metroeast Endoscopic Surgery Center.

16 MR. FREELAND: Good morning to the Board.
17 Thank you for allowing me to be here this morning.

18 My name is Mark Freeland. Previously, I
19 was the executive director of the Southern
20 Illinois Regional Wellness Center, which is a
21 Federally qualified health center. Prior to that
22 my healthcare career was a long-term care
23 administrator.

24 The mission of the wellness center is to

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1 improve the quality of life for underinsured and
2 uninsured individuals. I also represent today
3 other colleagues in the very qualified health
4 center community and providers in that community.

5 With this mission in mind, we support the
6 Surgery Center Project 19-43 for Metroeast Surgery
7 Center who seeks to add additional types of surgeons
8 to its medical staff. The surgery center is Joint
9 Commission accredited and provides the same high
10 quality surgical care as hospitals but typically
11 at a quarter of the cost.

12 For many folks in St. Claire County,
13 particularly those living in underserved high
14 poverty areas like East St. Louis, Belleville, and
15 Washington Park where we serve, the surgery center
16 is the only option for receiving affordable care
17 on the Illinois side of the St. Louis region.

18 While most surgery centers do not accept
19 Medicaid patients or only nominally accept them,
20 this surgery center serves nearly 1,000 Medicaid
21 patients every year and, in fact, it provides
22 60 percent of the Medicaid services in the three-
23 county area.

24 With the addition of more specialties this

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1 center can serve more low-income patients,
2 including those referred for specialist services
3 from the area Federally qualified health clinics.

4 Through my involvement with the Wellness
5 Center, I've seen firsthand the impact large
6 unexpected hospital bills have on patients and
7 their families. With the recent relocation of
8 St. Elizabeth's Hospital, along with physicians'
9 practices from nearby Belleville to O'Fallon, I
10 fear that low-income residents will have even more
11 difficulty finding providers willing to make
12 appointments for them and to access care. To
13 address this need, the surgery center seeks to
14 expand its scope of care to include key conditions
15 experience by the aging population.

16 On behalf of our Federally qualified
17 health center, I urge you to approve this
18 proposal. Thank you for your time.

19 MS. GUILD: Tracy Harris, Dialysis Care
20 Center Rockford.

21 MS. HARRIS: Good morning. My name is
22 Tracy Harris, and I came here today on behalf of
23 my doctors, and they're trying to open their own
24 clinic, okay, for the dialysis patients.

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1 Me, the experience I have had with
2 Dr. Mahmood and his team of doctors and all these
3 providers has been totally awesome. They have
4 given me my life back. I'm able to work now; I'm
5 able to walk downstairs to even do my laundry now.
6 And if I had to transition over -- if I go through
7 all this, and I don't get a transplant and I have
8 to go back into the hemodialysis, I would like to
9 go back to the hemodialysis with the team that I'm
10 working with now because I'm comfortable. They
11 are more like my family. I'm able to talk to
12 them. If I have a problem, I'm able to talk with
13 them and feel comfortable talking with them.

14 I don't want to go back to the clinic I
15 was at before. It was just uncomfortable. It was
16 almost like a cookie cutter type of thing, you
17 know, everybody was the same, you know.

18 And with that being said -- this is my
19 first time ever being like this, so I'm not --

20 MS. AVERY: You're fine.

21 MS. HARRIS: But please allow them to open
22 their clinic.

23 CHAIRWOMAN SAVAGE: Thank you, you did good.

24 MS. GUILD: Next is Jacqueline Trejo,

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1 Dialysis Care Center of Rockford.

2 MS. TREJO: My name is Jacqueline Trejo,
3 as well, with Tracy. I'm a patient at the Care
4 Clinic in Rockford. Dr. Mahmood is my doctor and
5 I've been with them for four years.

6 I feel as a dialysis patient we should
7 always have an option and we have -- I've always
8 felt this clinic to be part of my family. They
9 saved my life and thanks to them I'm able to live
10 a normal life, am able to be a mother, a wife.
11 And their work ethic is excellent, and I would
12 hate to have to transfer because of the -- of this
13 clinic not opening, especially now that I'm a
14 hemodialysis patient, I would like the opportunity
15 for you guys to reconsider and allowing them to
16 open this clinic because this also opens our
17 options as a patient.

18 Because I've always felt at home with
19 them. I feel like they are a part of my family,
20 and they've always made me feel happy. And, you
21 know, I've not always been an easy patient, but
22 they've been very patient with me, and I feel as
23 though if I go to another clinic it will be hard
24 for me to adapt to them.

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1 So I would really hope that you guys
2 reconsider for their own clinic and also for us
3 patients to have that option.

4 MS. GUILD: Thank you. Next is Blanca
5 Vigil Mendoza, Dialysis Care Center of Rockford.

6 MS. VIGIL: Hello. My name is Blanca
7 Vigil. I have a couple of things I want to talk
8 to you about. I want to tell you about my
9 experiences with DaVita because I've had to go
10 with them a couple of times before I was allowed
11 to go with DCC.

12 My very first experience with DaVita is when
13 I first got diagnosed with Irene IgA nephropathy,
14 which is kidney failure. And I live here in
15 Rockford, and it took us a bit for me to be able
16 to go to DaVita because I got diagnosed at 16.
17 Therefore, being a minor, nobody wanted to treat
18 me until finally I found a clinic 40 minutes away
19 from my house that would allow me to go in to get my
20 treatment. And there is two clinics 5 to 10 minutes
21 away from my house, one that I could walk to and
22 even more on the way to that other clinic. So
23 that was very frustrating.

24 And DaVita makes their patients feel only

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1 like a number. I got to the point where I didn't
2 want to ask for help because they just -- the way
3 they kind of like responded to it was very -- as a
4 patient it's just very uncomfortable. Yeah, the
5 nurses just -- they weren't very helpful.

6 Then I got to go to Madison, Wisconsin,
7 where I got my transplant, and I was willing to
8 make the hour-and-15-minute drive up there because
9 I did not want to go through DaVita anymore, and
10 they kept suggesting for me to get a clinic closer
11 to home, but I thought that meant that I would
12 have to go to DaVita, and I didn't want to, so I
13 did that for a year.

14 I got very attached to that nurse, and so
15 starting over was very hard, and it took me a
16 while to start trusting my DCC care staff but now
17 I love them. They are the best staff I've had.
18 Dr. Mahmood is an amazing doctor, one of the best
19 I've had. And my nurses, also, they --

20 MR. ROATE: Two minutes.

21 MS. VIGIL: -- are always there. Huh?

22 MR. ROATE: Two minutes.

23 MS. VIGIL: Okay. Yeah.

24 MS. GUILD: Thank you.

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1 Ken Ripstein, Javon Bea Hospital.

2 MR. RIPSTEIN: My name is Ken Ripstein. I
3 own and operate two skilled nursing facilities in
4 Rockford, Illinois, one which is directly across
5 the street from Mercy Hospital in Rockton who is
6 applying for CON.

7 I stand before you in support for the
8 approval of a CON for a 17-bed subacute unit. I
9 do so because there is a gap in the placement
10 system whereby certain categories of patients will
11 not be accepted for admission by skilled nursing
12 facilities such as sex offenders, patients with
13 severe criminal histories, patients with no
14 funding source and cannot pay for cost of care.
15 If skilled nursing homes will not accept these
16 patients, where do they go for the needed care?

17 The subacute unit amendment they have
18 described in their CON states that, quote, "No
19 patient who can be admitted to an existing skilled
20 nursing facility will be admitted into this new
21 unit." I am therefore in support of this unit.

22 MS. GUILD: Thank you.

23 Robin Ross, Burr Ridge Birth Center.

24 MS. ROSS: Yes, hi. Good morning. I'm

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1 here on behalf of the Burr Ridge Birth Center. I
2 am a birth doula, which means a professional labor
3 support person. I've been a birth doula for
4 12 years, and I've helped to support close to over
5 800 families in their actual labors and births in
6 and around the Chicagoland area, many in
7 hospitals, some at home, and a few in the
8 freestanding birth center located in Berwyn,
9 Illinois, which is in Cook County.

10 So what I'm here to talk about is the
11 need, the growing need for a birth center in
12 DuPage County to help support the also growing
13 needs of our community of women who are birthing
14 and want other options, safe options.

15 Me myself, I birthed my first two in a
16 hospital in DuPage County, and then my last was at
17 home here in Bolingbrook. I would have chosen a
18 birth center had I had the option to do so. I
19 feel that it is a better option for many,
20 especially those who travel from different areas,
21 to have a safe option for birth.

22 Home birth is an option here in the state
23 of Illinois. However, there are some women who
24 are not finding a good care provider, and many are

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1 doing unassisted home birth, which can be very
2 problematic to their health or their newborn's
3 health. So this is why having a freestanding
4 birth center as an option in DuPage County works
5 for the vast majority of the clients I support, as
6 well as those who would travel to this birth
7 center as an option to not have to go all the way
8 to Berwyn as the only other option for a
9 freestanding birth center.

10 And the reason for that is some are not
11 comfortable birthing in a hospital, and there are
12 some who are not comfortable birthing at home, so
13 having this as another option for the community is
14 really beneficial at large.

15 CHAIRWOMAN SAVAGE: Thank you.

16 Mr. Constantino, would you please read
17 into the record those items approved by the Chair
18 in accordance with the Illinois Health Facilities
19 Planning Act. Thank you.

20 MR. CONSTANTINO: Thank you, Madam Chair.

21 The first project was 17-041, Palos Hills
22 Surgery Center, a four-month permit renewal
23 request;

24 Project 18-020, Silver Cross Hospital in

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1 New Lenox, a 12-month permit renewal request;

2 Project 18-021, HSHS St. Elizabeth's
3 Hospital O'Fallon, a six-month permit renewal
4 request;

5 Project 16-030, Cook County John H. Stroger
6 Hospital, Chicago, a six-month permit renewal
7 request;

8 Project No. 18-008, Kildeer Ambulatory
9 Care Center in Kildeer, five-month permit renewal
10 request;

11 Project No. 18-005, DeKalb County Rehab &
12 Nursing, DeKalb, Illinois, 18-month permit renewal
13 request;

14 Project 17-062, DaVita Auburn Park
15 Dialysis, Chicago, 18-month permit renewal
16 request;

17 Exemption No. E-059-19, Eye Surgery Center
18 Swansea, change of ownership;

19 Exemption No. E-001-20, Kindred Hospital
20 in Sycamore, change of ownership;

21 Exemption No. E-002-20, Kindred Hospital,
22 Chicago, change of ownership;

23 Exemption No. E-003-20, Kindred Hospital,
24 Northlake, change of ownership;

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1 Exemption No. E-004-20, Kindred Hospital,
2 Chicago North, change of ownership;

3 Exemption No. E-007-20, Eyes of Illinois
4 Surgery Center, Maryville, change of ownership;

5 Project No. 17-018, DuPage Vascular Care,
6 Woodridge, relinquishment of permit;

7 Project No. 17-072, Illinois Vascular
8 Care, Schaumburg, relinquishment of permit.

9 Thank you, Madam Chair.

10 CHAIRWOMAN SAVAGE: Thank you.

11 Next item on the agenda, Item A-01,
12 Project 15-026, Vista Medical Center East in
13 Waukegan. May I have a motion to approve a
14 30-month permit renewal second request for
15 Project 15-026 Vista Medical Center East, Waukegan.

16 MEMBER MARTELL: I so move.

17 CHAIRWOMAN SAVAGE: A second.

18 MEMBER MURRAY: Second.

19 CHAIRWOMAN SAVAGE: Please identify
20 yourselves, spell your names for the court
21 reporter, and be sworn in.

22 MR. LAWLER: Dan Lawler, L-a-w-l-e-r,
23 CON council for Vista East.

24 MS. NEEDHAM: Kim Needham, N-e-e-d-h-a-m,

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1 chief operating officer for Vista Medical
2 Center-East.

3 MR. FITZGERALD: Ed Fitzgerald, the Vista
4 health facilities director. Last name is spelled
5 F-i-t-z-g-e-r-a-l-d.

6 (Witnesses sworn.)

7 CHAIRWOMAN SAVAGE: Mr. Constantino, would
8 you please read the staff's State Board report.

9 MR. CONSTANTINO: Thank you, Madam Chair.

10 Permit holders are asking the State Board
11 to approve a second permit renewal for this permit
12 from December 31st, 2019, until June 30th, 2022.

13 This permit was approved in August of
14 2015 to modernize the medical surgical units at the
15 hospital at a cost of approximately \$17.8 million.
16 The project is financially committed with the
17 signing of the construction contract. The delay
18 in completion of the project is a result of the
19 need to conserve capital by the hospital.

20 Thank you, Madam Chair.

21 CHAIRWOMAN SAVAGE: Thank you. Please
22 proceed with your statement to the Board.

23 MR. LAWLER: Yes. We submitted the
24 information required for the permit renewal, and

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1 we're here to answer any questions the Board may
2 have on it.

3 CHAIRWOMAN SAVAGE: Can you please go into
4 more detail.

5 MR. FITZGERALD: I can talk about the
6 schedule. We initially had a 13-month construction
7 scheduled. That was going to be in multiple
8 phases, and several of the units were going to be
9 done at the same time.

10 The additional request is we're going to
11 be doing one of the units not concurrently now so
12 that we have an opportunity to move some patients,
13 as well as capital outlay so that we can fund the
14 project throughout the entire 30 months that we're
15 requesting.

16 We did just receive yesterday confirmation
17 from our drawings review that there was no comments
18 and that we should be able to start construction
19 within three to four weeks of your approval.

20 CHAIRWOMAN SAVAGE: Any questions by the
21 Board?

22 MEMBER MARTELL: Can you respond to a
23 little bit about the capitalization?

24 MS. NEEDHAM: So our original project in

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1 2015 was funded by Community Health Systems for
2 that \$17.5 million original project. We were then
3 spun off to Quorum Health System quite a few
4 months later, and we started the abatement of the
5 first phase project about 900,000. At that point
6 in time, Quorum was looking at capital to hold back
7 just to fund all the other hospitals and their
8 needs, along with equipment and different infection
9 control issues that they had throughout the
10 facility. So our project was put on hold.

11 Again, an extension -- we did come before
12 this Board for another extension, and we're here
13 today as the funding has become available.

14 CHAIRWOMAN SAVAGE: Other questions or
15 comments from the Board? Staff?

16 MR. CONSTANTINO: This project isn't going
17 to be scaled back, is it?

18 MR. LAWLER: No.

19 MR. CONSTANTINO: Any change to the
20 project needs to be reported to the Board. I know
21 Mr. Lawler knows that.

22 MR. LAWLER: Thank you.

23 CHAIRWOMAN SAVAGE: Seeing no other
24 questions, I would ask for a roll call vote,

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1 Mr. Roate.

2 MR. ROATE: Thank you, Madam Chair.

3 Motion made by Dr. Martell; seconded by

4 Dr. Murray.

5 Senator Demuzio.

6 MEMBER DEMUZIO: Yes.

7 MR. ROATE: Thank you.

8 Dr. Martell.

9 MEMBER MARTELL: Yes.

10 MR. ROATE: Thank you.

11 Dr. Murray.

12 MEMBER MURRAY: Yes.

13 MR. ROATE: Thank you.

14 Mr. Slater.

15 MEMBER SLATER: Yes.

16 MR. ROATE: Thank you.

17 Chairwoman Savage.

18 CHAIRWOMAN SAVAGE: Yes.

19 MR. ROATE: Thank you.

20 That's 5 votes in the affirmative.

21 CHAIRWOMAN SAVAGE: And the motion is

22 approved. Thank you.

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1 CHAIRWOMAN SAVAGE: Next on the agenda,
2 Item A-02, Project 16-042, Fresenius Kidney Care
3 Paris Community in Paris. May I have a motion to
4 approve a 12-month permit renewal second request
5 for Project 16-042, Fresenius Kidney Care Paris
6 Community in Paris.

7 MEMBER SLATER: I so move.

8 CHAIRWOMAN SAVAGE: Second.

9 MEMBER DEMUZIO: Second.

10 CHAIRWOMAN SAVAGE: Please identify
11 yourself, spell your name for the court reporter,
12 and be sworn in.

13 MS. WRIGHT: Lori Wright, L-o-r-i
14 W-r-i-g-h-t. I'm the CON specialist for Fresenius
15 Medical Care.

16 (Witness sworn.)

17 CHAIRWOMAN SAVAGE: Mr. Constantino, if
18 you can please read the staff's State Board report.

19 MR. CONSTANTINO: Thank you, Madam Chair.

20 The permit holders are asking the State
21 Board to approve second permit renewal for this
22 permit from March 31st, 2020, to March 31, 2021.

23 This permit was approved in March of
24 2017 to establish an 8-station ESRD facility on the

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1 campus of Paris Community Hospital at a cost of
2 \$2.7 million. Delay in completion of the project
3 is a result of an ongoing modernization project at
4 the hospital that delayed the signing of the lease.

5 This project is financially committed and
6 according to the permit holders is approximately
7 50 percent completed.

8 Thank you, Madam Chair.

9 CHAIRWOMAN SAVAGE: Thank you. If you
10 would like to proceed with your statement for the
11 Board.

12 MS. WRIGHT: Sure. Like Mike said, the
13 hospital had their own renovation in the works
14 when we got the CON permit for this, we were
15 unaware that we had to wait for them to finish
16 their plans and then finish their construction in
17 order for our space to be ready to do the interior
18 buildout, and the lease negotiations took longer
19 than expected. We were going with a turnkey lease
20 for a long time, which means the hospital would do
21 our interior buildout, and we would pay it back
22 over the term of the lease. In the end we decided
23 to do the interior buildout ourselves. So that
24 meant some changes to the lease.

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1 The lease is signed now. We do have floor
2 plans that have been approved. We anticipate
3 going to bid for a contractor in approximately
4 30 to 45 days and then expect to begin construction
5 in about 60 days. The interior buildout will take
6 about 90 days, and so we hope to open approximately
7 by September and then just await certification.
8 So we are on track now to get rolling with the
9 actual construction.

10 CHAIRWOMAN SAVAGE: Thank you.

11 Other questions?

12 (No response.)

13 CHAIRWOMAN SAVAGE: Seeing none, I would
14 ask for a roll call vote, Mr. Roate.

15 MR. ROATE: Thank you, Madam Chair.

16 Motion made by Mr. Slater; seconded by
17 Senator Demuzio.

18 Senator Demuzio.

19 MEMBER DEMUZIO: Yes, based upon the
20 comments of the project and also Mr. Constantino's
21 comments.

22 MR. ROATE: Thank you.

23 Dr. Martell.

24 MEMBER MARTELL: Yes, based on staff

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1 report and testimony provided today.

2 MR. ROATE: Thank you.

3 Mr. Slater.

4 MEMBER SLATER: Yes, based on staff
5 report.

6 MR. ROATE: Sorry. Dr. Murray.

7 MEMBER MURRAY: Yes, based on staff report
8 and testimony.

9 MR. ROATE: Thank you.

10 Chairwoman Savage.

11 CHAIRWOMAN SAVAGE: Yes, based on staff
12 report and testimony.

13 MR. ROATE: Thank you.

14 That's 5 votes in the affirmative.

15 CHAIRWOMAN SAVAGE: The motion is
16 approved. Thank you.

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1 CHAIRWOMAN SAVAGE: So next on the agenda,
2 Item C-01, Project E-005-20, Pipeline West
3 Suburban Medical Center in Oak Park. May I have a
4 motion to approve Exemption E-005-20, Pipeline
5 West Suburban Medical Center for a change in
6 ownership.

7 MEMBER MARTELL: I so move.

8 CHAIRWOMAN SAVAGE: Second.

9 MEMBER MURRAY: Second.

10 CHAIRWOMAN SAVAGE: Please identify
11 yourselves, spell your names for the court
12 reporter, and be sworn in.

13 MR. ORZANO: Nicholas Orzano with Pipeline
14 Health. Last name is O-r-z-a-n-o.

15 MS. MURPHY: Ann Murphy, regulatory
16 counsel to the applicants, M-u-r-p-h-y.

17 MS. SHEHAN: Mary Shehan, CEO for Weiss,
18 S-h-e-h-a-n.

19 (Witnesses sworn.)

20 CHAIRWOMAN SAVAGE: Mr. Constantino,
21 please give your State Board staff report.

22 MR. CONSTANTINO: Thank you, Madam Chair.

23 The applicants are asking the State Board
24 to approve a change of ownership of an existing

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1 236-bed hospital in Oak Park, Illinois. The public
2 hearing on this change of ownership was conducted
3 by the State Board on February 3rd, 2020, at the
4 Oak Park Public Library.

5 This change of ownership is considered a
6 stop transfer resulting in a change of control of
7 a licensed healthcare facility with no change in
8 the current licensee. There is no cost to this
9 transaction and the fair market value of the
10 hospital is approximately \$33.3 million. The
11 applicants have provided all the information
12 required by the Board.

13 Thank you.

14 CHAIRWOMAN SAVAGE: Thank you. If you'd
15 please proceed with your statement to the Board.

16 MR. ORZANO: Members of the Board, thank
17 you for the opportunity to testify today. My name
18 is Nick Orzano. I serve as the manager of
19 Pipeline Health.

20 Today there are two applications before the
21 Board in connection with the proposed corporate
22 reorganization. This would make Weiss Memorial
23 Hospital and West Suburban Medical Center part of
24 the national Pipeline Health System corporate

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1 structure. Neither hospital is currently part of
2 that national structure. Out of respect for your
3 time, I'll consolidate my remarks for both
4 applications into a single presentation.

5 The primary purpose of this corporate
6 reorganization is to facilitate Pipeline's
7 expanded and enhanced health care services at
8 these two hospitals to benefit the communities
9 they serve. We're respectfully asking that these
10 applications be approved today by the Board. As
11 has been noted, the applications were deemed
12 complete by Board staff, have been deemed to
13 conform with the applicable standards by Board
14 staff, and were the subject of public hearings
15 that we initiated in the spirit of transparency.
16 There has been no written opposition.

17 In 2019 Pipeline purchased these hospitals
18 from the previous owner, Tenet. In making the
19 decision to do so, we drew on our substantial
20 experience in successfully operating hospitals in
21 medically underserved communities outside
22 Illinois.

23 As this Board knows, hospitals across
24 Illinois continue to face complex financial

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1 challenges brought on by advances in medicine,
2 changes in Federal funding, and Illinois' managed
3 care for Medicaid patients. The road hasn't been
4 easy for many hospitals, especially community
5 hospitals in cities that provide care to many
6 underinsured or uninsured patients. We've seen
7 some close and others merge.

8 We believe in community hospitals and that
9 they will continue to be part of the healthcare
10 system. But so, too, will the challenges. The
11 question is how to help both Weiss and West
12 Suburban adapt so they can continue serving their
13 communities. We believe there are several key
14 things that need to happen.

15 First is to make them part of the national
16 corporate Pipeline Health System. Currently
17 neither hospital is within Pipeline Health
18 System's corporate structure, which includes our
19 hospitals in Dallas and Los Angeles. These
20 hospitals, like the two here in Illinois, provide
21 care to many underserved patients. By making
22 Weiss and West Suburban part of the Pipeline
23 Health System national structure, this would allow
24 us to make additional strategic, management, and

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1 operational resources available.

2 Second, the leadership of these hospitals
3 and Pipeline will have to continually rethink how
4 we serve patients and meet their needs, even if
5 that doesn't parallel past practices. We will
6 need to leverage technology and increase
7 efficiencies so that as many dollars as possible
8 go to care, not to overhead.

9 Finally, the path forward for each of
10 these hospitals to have a strong future comes
11 through growth and playing to the strengths of
12 each. At Weiss, for example, we want to
13 strengthen the geriatric behavioral health
14 inpatient program, become a certified center for
15 excellence for gender confirmation surgery, and
16 grow the outpatient behavioral health program.

17 At West Suburban we want to grow the
18 orthopedic program and upgrade to 3D mammography
19 equipment to enhance the women's health center.
20 We also need to continue strengthening the
21 partnership with PCC Community Wellness Center on
22 West Suburban's campus. This is a Federally
23 qualified health center that serves many patients
24 with little financial means.

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1 To pursue all of this, though, the
2 hospitals should come under the Pipeline Health
3 System corporate structure. Weiss and West
4 Suburban are critical to the communities they
5 serve. Being a part of Pipeline's health system
6 will allow them to adapt so they can continue to
7 do that. It's why, again, I respectfully ask the
8 Board to approve our applications.

9 I'm happy to answer any questions.

10 MS. MURPHY: Madam Chair, would you like
11 to hear now from the CEO for Weiss even though
12 that application is technically not before you?

13 CHAIRWOMAN SAVAGE: If you'd like to go
14 now, that's fine.

15 MS. SHEHAN: Members of the Board, thank
16 you for your time today. I'm Mary Shehan, the CEO
17 of Weiss Memorial Hospital, which is one of the
18 two applications before this body today. I am
19 hopeful that you will approve them to make my
20 hospital, along with our sister hospital, West
21 Suburban, part of the Pipeline Health System
22 corporate structure.

23 During my four decades in healthcare as a
24 bedside nurse and now as an administrator I've

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1 never seen such rapid advances in medicine and the
2 grueling pace of change in the policy and
3 economics of healthcare. More than ever we need
4 to be part of a health system.

5 I came to Weiss when it was owned Tenet as
6 the chief nursing officer after 23 years at
7 Swedish Covenant Hospital. While I served in that
8 role, we had seen three CEOs in rather rapid
9 succession. I became the final CEO under Tenet's
10 ownership. Shortly afterwards, Tenet began its
11 divestiture of Weiss.

12 During the four decades of my medical
13 career, I have been fortunate to have broad,
14 diverse, and high-level opportunities, first as a
15 clinical nurse, and then as a professor, and now
16 as a hospital administrator. They have provided
17 me with rewarding work and at this stage of my
18 career the option to chart my own course and head
19 in a different direction if I truly wanted. I
20 could have left when Pipeline purchased the
21 hospital but I didn't, despite the challenges,
22 because I believe in the work that we are doing
23 every day to provide care to our community.

24 I know that there will be many more

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1 challenges. Weiss, like many community hospitals,
2 faces drastic changes in medicine, greater
3 pressures to reduce costs and to meet growing
4 expectations by patients.

5 Growth and care of patients will be key
6 for Weiss' future. That will require us not only
7 to meet the current needs of the community
8 surrounding us but to do two additional things.
9 First, build a better partnership with West
10 Suburban Medical Center, and second, to open and
11 expand programs. Already we have started to
12 explore opportunities with women's health and
13 rehabilitative care. To achieve this, it requires
14 more capital and strategic leadership we simply
15 cannot do this alone as a freestanding hospital.
16 The economics are too complex.

17 I've chosen to stay and to lead this at
18 this critical time despite challenges because the
19 Uptown community and its diverse residents, the
20 elderly, many in the LGBTQ community, and others
21 are my life. More than ever we need you to
22 approve this application so the people I lead can
23 continue to provide care at Weiss for many decades
24 to come.

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1 I'm happy to answer any questions.

2 Thank you.

3 CHAIRWOMAN SAVAGE: Thank you. Any
4 questions from the Board or staff?

5 (No response.)

6 CHAIRWOMAN SAVAGE: Okay. Seeing none, I
7 would ask for a roll call vote, Mr. Roate, for
8 Pipeline West Suburban Medical Center.

9 MR. ROATE: Thank you, Madam Chair.

10 Motion made by Dr. Martell; seconded by
11 Dr. Murray.

12 Senator Demuzio.

13 MEMBER DEMUZIO: Yes, based upon the staff
14 report and testimony.

15 MR. ROATE: Thank you.

16 Dr. Martell.

17 MEMBER MARTELL: Yes, based on staff
18 report and testimony.

19 MR. ROATE: Thank you.

20 Dr. Murray.

21 MEMBER MURRAY: Yes, based on staff report
22 and testimony.

23 MR. ROATE: Thank you.

24 Mr. Slater.

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1 CHAIRWOMAN SAVAGE: Next item is C-02,
2 Project E-006-20, Pipeline Louis E. Weiss Memorial
3 Hospital in Chicago. May I have a motion to
4 approve Exemption E-006-20, Pipeline Louis A.
5 Weiss Memorial Hospital for a change of ownership.

6 MEMBER MURRAY: So moved.

7 CHAIRWOMAN SAVAGE: A second.

8 MEMBER MARTELL: Second.

9 CHAIRWOMAN SAVAGE: Do you have any other
10 comments?

11 (No response.)

12 CHAIRWOMAN SAVAGE: So, Mr. Constantino,
13 if you could give our State Board staff report.

14 MR. CONSTANTINO: Thank you, Madam Chair.

15 The applicants are asking the State Board
16 to approve a change of ownership of an existing
17 237-bed hospital in Chicago, Illinois. A public
18 hearing on this change of ownership was conducted
19 by the State Board on February 3rd, 2020, at the
20 Uptown branch of the Chicago Public Library.

21 This change of ownership is considered a
22 stock transfer resulting in a change of control of
23 a licensed healthcare facility with no change in
24 the current licensee. There's no cost to this

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1 transaction, and the fair market value of the
2 facility is approximately \$25.2 million. The
3 applicants have provided all the information
4 required by the State Board.

5 Thank you.

6 CHAIRWOMAN SAVAGE: Thank you.

7 Any questions?

8 (No response.)

9 CHAIRWOMAN SAVAGE: Okay. Seeing none,
10 Mr. Roate, roll call.

11 MR. ROATE: Thank you, Madam Chair.

12 Motion made by Dr. Murray; seconded by
13 Dr. Martell.

14 Senator Demuzio.

15 MEMBER DEMUZIO: Yes, based on the staff
16 report and testimony.

17 MR. ROATE: Thank you.

18 Dr. Martell.

19 MEMBER MARTELL: Yes, based on staff
20 report and testimony.

21 MR. ROATE: Thank you.

22 Dr. Murray.

23 MEMBER MURRAY: Yes, based on staff report
24 and testimony.

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1 MR. ROATE: Thank you.

2 Mr. Slater.

3 MEMBER SLATER: Yes, based on the
4 transcript of the public hearing, testimony here,
5 and the staff report.

6 MR. ROATE: Thank you.

7 Chairwoman Savage.

8 CHAIRWOMAN SAVAGE: Yes, based on the
9 items stated.

10 MR. ROATE: Thank you.

11 That's 5 votes in the affirmative.

12 CHAIRWOMAN SAVAGE: So that motion is
13 approved. Thank you.

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1 CHAIRWOMAN SAVAGE: Next on the agenda is
2 Declaratory Rulings. Item E-01 King-Bruwaert
3 House in Burr Ridge, may I have a motion to
4 approve a correction to their long-term care
5 profiles for 2016, 2017, and 2018 for
6 King-Bruwaert House in Burr Ridge.

7 MEMBER SLATER: I move to approve.

8 CHAIRWOMAN SAVAGE: Second.

9 MEMBER MURRAY: Second.

10 CHAIRWOMAN SAVAGE: If you would please
11 identify yourself, spell your last name for the
12 court reporter, and be sworn in.

13 MR. KINERY: Good morning. My name is
14 John Kinery, K-i-n-e-r-y, healthcare consultant
15 for the applicant. With me is Jeremy Leone,
16 comptroller for the applicant -- for the facility.

17 (Witnesses sworn.)

18 CHAIRWOMAN SAVAGE: Mr. Constantino, if
19 you could give the State Board staff report.

20 MR. CONSTANTINO: Thank you, Madam Chair.

21 The nursing home is a 49-bed long-term
22 facility located in Burr Ridge, Illinois. The
23 Board staff is asking the Board to approve changes
24 to the long-term care profile data for years 2016,

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1 2017, and 2018.

2 According to the nursing home the mistake
3 was a result of a major change in the internal
4 financial accounting department. According to the
5 nursing home, this has been corrected.

6 Thank you, Madam Chair.

7 CHAIRWOMAN SAVAGE: Please proceed with
8 your statement to the Board.

9 MR. KINERY: Good morning, Madam Chair,
10 Members of the Board. Again, my name is John
11 Kinery.

12 Essentially, this was a scrivener's error.
13 The only number that was wrong was the patient bay
14 number on the entire inventory.

15 I was contacted with some associates and
16 brought in to look and do planning, help them with
17 their planning, and, obviously, the first thing we
18 look at is their IDPH profiles, and I saw this
19 error. We're just bringing it to your attention
20 trying to correct the record.

21 CHAIRWOMAN SAVAGE: I do have a question.
22 What plan do you have going forward to prevent a
23 recurrence of this issue?

24 MR. KINERY: That's why I brought Jeremy

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1 with me today. Jeremy is new the last two years,
2 and he is now responsible for doing these reports
3 and having the administrator sign off.

4 MR. LEONE: It was just in the
5 transitional period the person that left dropped
6 the ball, and then I came in and knew how to do
7 the report properly, so I plan to have the
8 administrator review it on an annual basis.

9 CHAIRWOMAN SAVAGE: Other Board questions?
10 (No response.)

11 CHAIRWOMAN SAVAGE: Mr. Roate, if we could
12 have the roll call vote.

13 MR. ROATE: Thank you, Madam Chair.

14 Motion made by Mr. Slater; seconded by
15 Dr. Murray.

16 Senator Demuzio.

17 MEMBER DEMUZIO: Yes, based upon the staff
18 report but also the testimony that there is a plan
19 in place to correct it.

20 MR. ROATE: Thank you.

21 Dr. Martell.

22 MEMBER MARTELL: Yes, I support the
23 corrections to be made.

24 MR. ROATE: Thank you.

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Dr. Murray.

MEMBER MURRAY: Yes.

MR. ROATE: Thank you.

Mr. Slater.

MEMBER SLATER: Yes, based on the staff
report.

MR. ROATE: Thank you.

Chairwoman Savage.

CHAIRWOMAN SAVAGE: Yes, based on the
staff report and testimony.

MR. ROATE: Thank you.

That's 5 votes in the affirmative.

CHAIRWOMAN SAVAGE: The motion is
approved. Thank you.

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1 CHAIRWOMAN SAVAGE: So next on the agenda
2 is Item H-01, Project 19-022, Austin Dialysis at
3 Loretto in Chicago.

4 May I have a motion to approve an
5 establishment of a 12-station ESRD facility for
6 Project 19-022, Austin Dialysis at Loretto.

7 MEMBER DEMUZZIO: Motion.

8 CHAIRWOMAN SAVAGE: A second.

9 MEMBER MURRAY: Second.

10 CHAIRWOMAN SAVAGE: Please identify yourself,
11 spell your name, and be sworn in.

12 MR. HYLAK-REINHOLTZ: Good morning, Madam
13 chairman. Joseph Hylak-Reinholtz, H-y-l-a-k,
14 hyphen, R-e-i-n-h-o-l-t-z. I am the new counsel
15 representing the applicant, Loretto Hospital.

16 I'm here today to ask for a Board deferral.
17 I have to appear before the Board because we are
18 out of regular deferrals that the applicant can
19 ask for without coming before the Board. We have
20 to do this for two reasons. One, we're out of the
21 timeline to do an applicant deferral, but, in
22 addition, we need to now make a modification to
23 the application. Per 1130.650 of your Board rules,
24 we are adding a coapplicant, which is a Type A

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1 modification, which is going to require
2 resubjecting us to the public hearing and notice
3 requirements.

4 So we would make a modification to add a
5 coapplicant to the application. If you'd like
6 further discussion about this, I'd be happy to
7 give you a CliffNotes version.

8 THE COURT REPORTER: He's not been sworn.
9 Will you raise your right hand, please.
10 (Witness sworn.)

11 CHAIRWOMAN SAVAGE: So, Mike, if we can
12 have the State Board staff report.

13 MR. CONSTANTINO: Thank you, Madam Chair.
14 The applicants are asking the State Board
15 to approve the establishment of a 12-station ESRD
16 facility in Chicago, Illinois, at a cost of
17 approximately \$1.96 million. No public hearing
18 was requested, and the Board staff did receive
19 support and opposition letters which are included
20 at the end of your report. The applicants
21 addressed a total of 22 criteria and failed to
22 meet 5 of those criteria.

23 Thank you, Madam Chair.

24 CHAIRWOMAN SAVAGE: Thank you.

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1 So I have many, many questions about what
2 we would ask, and I would encourage you-all to
3 work with our State Board as you work through your
4 referral.

5 So now a roll call vote for deferral.

6 MR. ROATE: Thank you, Madam Chair. Do we
7 call a new motion, or can we use the existing
8 motion?

9 MR. KINERY: For deferral.

10 MS. AVERY: Oh, yes. Sorry, George,
11 thank you.

12 CHAIRWOMAN SAVAGE: So may I have a motion
13 to defer an establishment of this 12-station ESRD
14 facility for Project 19-022, Austin Dialysis at
15 Loretto.

16 MEMBER MARTELL: I so move.

17 CHAIRWOMAN SAVAGE: A second.

18 MEMBER SLATER: Second.

19 MR. ROATE: Motion made by Dr. Martell,
20 second by Mr. Slater.

21 Senator Demuzio.

22 MEMBER DEMUZIO: Yes.

23 MR. ROATE: Thank you.

24 Dr. Martell.

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1 MEMBER MARTELL: Yes, in support of the
2 deferral.

3 MR. ROATE: Thank you.
4 Dr. Murray.

5 MEMBER MURRAY: Yes.

6 MR. ROATE: Thank you.
7 Mr. Slater.

8 MEMBER SLATER: Yes.

9 MR. ROATE: Thank you.
10 Chairwoman Savage.

11 CHAIRWOMAN SAVAGE: Yes.

12 MR. ROATE: Thank you.
13 That's 5 votes in the affirmative.

14 CHAIRWOMAN SAVAGE: So the motion for
15 deferral is approved. Thank you.

16 Would anyone on the Board need a break?

17 MS. AVERY: Yes.

18 CHAIRWOMAN SAVAGE: So we'll take a
19 10-minute break, and then we'll come back with H-02.

20 (Recess taken, 10:34 a.m. to 10:47 a.m.)

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1 CHAIRWOMAN SAVAGE: So welcome back. Now
2 we're going to move on to Item H-02, Project 19-036,
3 Encompass Health Rehabilitation Hospital of
4 Libertyville, LLC, in Libertyville.

5 May I have a motion to approve an
6 establishment of a 60-bed rehabilitation hospital
7 for Project 19-036, Encompass Health Rehabilitation
8 Hospital of Libertyville, LLC, Libertyville.

9 MEMBER SLATER: Move to approve.

10 CHAIRWOMAN SAVAGE: Second.

11 MEMBER MURRAY: Second.

12 CHAIRWOMAN SAVAGE: Please identify
13 yourself, spell your last name, and be sworn in.

14 MR. SILBERMAN: Mark Silberman, S-i-l-b,
15 as in "boy," -e-r-m-a-n, with Benesch.

16 MS. CHAFIN: Marty Chafin with Chafin
17 Consulting Group. You have my card.

18 MS. BREWER: Jennifer Brewer. I'm a
19 regional vice president with Encompass Health.
20 It's B-r-e-w-e-r.

21 DR. TALTY: Dr. Stephen Talty, T-a-l-t-y.

22 MR. MORADO: Juan Morado, Jr., with
23 Benesch. It's M-o-r-a-d-o.

24 (Witnesses sworn.)

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1 CHAIRWOMAN SAVAGE: Mr. Constantino, if
2 you could please give the State Board staff report.

3 MR. CONSTANTINO: Thank you, Madam Chair.

4 The applicants are asking the State Board
5 to approve the establishment of a 60-bed
6 comprehensive physical rehabilitation hospital in
7 Libertyville, Illinois, at a cost of approximately
8 \$52.2 million.

9 No public hearing was requested, and the
10 State Board staff did receive a number of letters
11 of support for this project. A list of those
12 support letters is provided in the executive
13 summary to your report and included in your packet
14 of information and on the State Board's website.
15 The applicants address a total of 19 criteria and
16 failed to meet 5 of those criteria.

17 I would like to point out one error that I
18 made in the report. Under "New Construction and
19 Contingency Costs," it should read a difference of
20 6255 rather than 11888. The applicants still
21 exceed the standard but by 2.7 million rather than
22 approximately 5.3. This was a result of me
23 failing to get the most recent RSMeans number. I
24 apologize for that.

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1 Also, in front of you are handouts that
2 reflect what's on these poster boards in front of
3 you, and all of this information was included in
4 the application for permit.

5 Thank you, Madam Chair.

6 CHAIRWOMAN SAVAGE: Thank you. So please
7 proceed with your statement to the Board.

8 MR. SILBERMAN: Thank you, Madam Chair.

9 We want to start by thanking the Board and
10 its staff for the assistance it's provided
11 throughout this process and for its overwhelmingly
12 positive staff report. And we also want to thank
13 the public, both political leaders and healthcare
14 professionals who came forward to support this
15 project. We were proud to have received 35 letters
16 of support, and more importantly, we were very
17 pleased to have absolutely no opposition for this
18 project.

19 As we mentioned, today I have with me --
20 next to me is Marty Chafin, who is the president
21 of Chafin Consulting. Next to her is Jennifer
22 Brewer, who is the regional vice president for the
23 central region of Encompass. Next to her is
24 Dr. Stephen Talty. He is medical director at the

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1 VanMatre Rehabilitation Hospital, which is a joint
2 venture between Encompass and Mercy Health. And
3 finally, Juan Morado, my partner from Benesch Law.

4 Since everyone agrees with regards to this
5 project that there absolutely is a need for these
6 services, what we're going to focus our
7 presentation on today is Encompass taking this
8 opportunity just to explain to the Board the
9 services that Encompass provides and its
10 philosophy towards and experience in providing
11 inpatient rehabilitation. The range of the
12 conditions and the types of patients that we
13 provide, especially pointing out that our expected
14 patient population for this facility is over
15 70 percent Medicaid and Medicare. We'll also
16 provide an explanation as to how we've identified
17 a need for the services that, while consistent
18 with the Board's need methodology, it does exceed
19 and how that methodology identified this need.
20 And then, finally, Juan is going to walk through
21 the limited findings and why we're confident that
22 this is a well-designed project that will provide
23 necessary and quality care in a way that will
24 meaningfully impact both the lives of the patients

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1 and will benefit the community that is currently
2 without access to this necessary care in this area.

3 So, as Mike mentioned, all of you have
4 handouts. The handouts are consistent with the
5 poster boards and all do reflect information that
6 was contained within the application and within
7 the State Board staff report, but we just thought
8 this might make it a little bit easier as the
9 witnesses refer to the different slides.

10 And with that I'm going to hand things off
11 to Jennifer Brewer.

12 MS. BREWER: Good morning. I've worked
13 with Encompass for 11 years now. 10 and a half
14 of those have been as a hospital CEO where I've
15 had the opportunity to work with patients, over
16 15,000 patients in starting a road to
17 recovery.

18 So a little bit about what our patients
19 look like, what our patients in Libertyville would
20 look like. Our patient who is 80 years old, who
21 trips on his rug, hits his head and suffers from a
22 brain bleed but wants to return to home and be in
23 his home comes to Encompass Health. He comes to
24 us to help restore his muscle tone and make sure

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1 he's safe to be at home again and make sure that
2 his cognitive impairments are addressed and he's
3 able to balance his checkbook and do things as
4 simple as remember to turn his stove off to keep
5 him home and in his community as long as possible.

6 We also take care of the 67-year-old new
7 grandmother who is desperate to hold her first
8 grandbaby after she's had a debilitating stroke.
9 We restore the left side of her body, giving her
10 the opportunity to hold that new grandchild.

11 We take care of the 35-year-old mother of
12 three who may have been undergoing chemotherapy
13 for the last several months who wants nothing more
14 than to have dinner with her family again at a
15 kitchen table versus in her bed.

16 We also take care of the 18-year-old who
17 has had a motor vehicle accident who is looking to
18 us to help him get through major milestones, such
19 as graduation, walking across that stage.

20 Those are the people we serve. So where
21 we do that is really, really important. Getting
22 patients back to their community is critical.

23 When I've talked to our patients and
24 families throughout the years, one common theme

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1 exists, and that common theme is that their
2 biggest fear is that they're going to be a burden
3 on their family. So getting care close to home is
4 critical to them being successful in living
5 independently.

6 Our hospitals are specifically designed
7 with two things in mind. We deliver high-dose
8 therapy in a highly motivated environment. Without
9 those two things, the patient won't have an
10 optimal outcome.

11 So high-dose therapy for us includes
12 three hours of intensive rehab a day, and we do
13 that complemented with 21 other hours of services
14 with specialized nurses, respiratory therapists,
15 wound care therapists, and many other professionals.
16 Highly motivating environment.

17 So if you come to an Encompass Health
18 hospital, you'll find very large, robust gym
19 space. Those gym spaces are highlighted with
20 bright lights, with very, very sophisticated
21 equipment that helps aid our therapy professionals
22 in delivering high-quality care.

23 Our hospitals are designed with input from
24 our clinicians, including nurses and therapists

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1 and physicians, but most importantly with our
2 long-term history in providing rehabilitation in
3 the communities that we serve, we want to hear
4 feedback from our patients. So the hospitals that
5 you see in front of you today are designed with
6 the patient's input in mind.

7 So the 60-bed Libertyville Hospital
8 location would be responsible for restoring the
9 quality of life for those patients that look like
10 the ones I described above. And I'm so grateful
11 for the opportunity to share my experience with
12 you today.

13 MR. TALTY: Good morning. Thank you for
14 giving me the opportunity to talk to you about
15 acute rehab. My name is Dr. Stephen Talty. My
16 experience after training at the University of
17 Chicago, now known as Shirley Ryan AbilityLab,
18 I've practiced for 30 years in various positions
19 such as heads of departments, president of medical
20 staffs, and currently serve as medical director of
21 an acute rehab unit in Rockford which is a joint
22 venture by Encompass and Mercy Health.

23 Why acute rehab? Acute rehab as opposed
24 to rehab in any other setting is indicated for

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1 patients who have had some type of decline in their
2 self-care skills and mobility that can benefit
3 from intensive therapy services, three hours of
4 therapy a day. Those services are indicated for
5 patients with diagnoses such as spinal cord
6 injury, brain injury, stroke, amputation,
7 neurological conditions like multiple sclerosis.
8 The patients can benefit from the intensity of
9 services three hours a day, and acute rehab has
10 been beneficial in preventing admissions to
11 hospitals. I've worked in hospitals; I've worked
12 in skilled nursing facilities, outpatient. My
13 experience is that acute rehab is most beneficial
14 to those patients that require the acuity of
15 specific nursing, too, rehab certified nurses.
16 Acute rehab brings together those high acuity
17 patients and a subspecialization of nursing rehab
18 nurses which you rarely find in other settings.

19 I believe that the rehab unit which doesn't
20 exist in that area right now could greatly benefit
21 the patients and facilitate return home, and
22 prevent readmissions, and offer them better
23 quality of life. We involve patients' families,
24 too, in acute rehab, family conferences and weekly

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1 meetings, as well. I believe the services are
2 desperately needed, and I think we can service the
3 community well.

4 MS. CHAFIN: Good morning. I'm Marty
5 Chafin with Chafin Consulting Group. The role
6 that I have here today is to walk you through the
7 market assessment.

8 I completed the market analysis for this
9 bed need. I believe firmly that there is a need
10 for 60 beds, and whereas, Jennifer and Dr. Talty
11 spoke from Encompass' standpoint, I'm going to
12 flip that on its head and talk about the community
13 and the community need for it. I'm hoping to find
14 a sweet spot between giving you enough detail of
15 the analysis that you're comfortable and agree
16 with me that there is a need for 60 beds but not
17 so much that your head hits the table because of
18 the data. So I'll work with you on that one if
19 I can.

20 By way of background, I have been in
21 healthcare for 33 years now since graduating from
22 Georgia Tech. I have been predominantly on the
23 consulting side. I also have worked on the
24 healthcare provider side for integrated health

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1 system that had postacute care, general acute
2 care, as well as inpatient rehab, skilled nursing,
3 and home health; they had a full continuum.

4 With that I'm going to jump into the
5 handouts. You all have the handouts in front of
6 you. Jennifer described briefly the facility,
7 which is page 1. Dr. Talty spoke about the type
8 of patients that you see, which is page 2. I'm
9 going to start with page 3.

10 The bed need methodology that the Board has
11 adopted shows that there is a need for 40 beds.
12 So inherently, if there is a need for 40 beds, you
13 know that there is a gap in care. As part of the
14 analysis, where I started was, what does that gap
15 in care look like? What is the number of beds per
16 population for HSA 8, and how does that compare to
17 the other HSAs throughout the state.

18 If you look at page 3, I want to make a
19 couple of points. One is that, just to get us all
20 oriented, the project will be located in Lake
21 County. The blue circle on the map shows Lake,
22 McHenry, and Kane Counties. That's the service
23 area, HSA 8. It is approximately 1.8 million
24 people projected for 2024. There are no rehab

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1 beds in Lake County; there are no rehab beds in
2 McHenry County. There are only two providers in
3 Kane County. Again, that's 1.8 million people.

4 If we carve out Chicago for just a minute
5 in the discussion, that is the largest HSA in
6 terms of population in your state. The graph that
7 you see in front of you goes largest to smallest
8 in terms of beds per thousand population. So the
9 left-hand side is the most beds per population,
10 down to the right-hand side that is the smallest.

11 What you see is that HSA 8 ranks absolute
12 last. It is the lowest in the state in terms of
13 beds per pop. The red line that you see on page 3
14 is the statewide average of beds per population.
15 That's the .116. For order of magnitude, the
16 difference between HSA 8 beds per pop and the
17 state average is about a threefold difference. So
18 that is why coming out of the gate my phrase will
19 be, "There's a gap in care." You know it; you've
20 said there's a bed need. This page 3 shows it, as
21 well, in terms of beds per pop.

22 The box at the bottom of that page, very
23 quickly, if the beds are approved, all 60, HSA 8,
24 again the most populated area outside of Chicago

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1 would go from last, ranking 11th out of 11 to 9.
2 So it would help address that gap in care and
3 provide beds that are needed.

4 Page 4 is really the crux of the matter,
5 and this is taking us from, we know there's a gap
6 in care when we look at beds per pop, but how do
7 we define how many beds are needed? Because the
8 beds are not there now, we can't really look at
9 historical utilization. It's more appropriate to
10 identify what the need is rather than what has
11 been occurring because there's not beds to be
12 utilized.

13 There are three separate approaches that I
14 used for the methodology, and I guess I should say
15 the role was, as I said, the market analysis I
16 completed and the CON application that I developed
17 from that.

18 If you look at page 4, two of the three
19 methodologies are from the Board. They're yours,
20 if you will. Line 1, which is the bed need based
21 on the need calculations in the rules, and then
22 line 3, which is what do the physicians out there
23 say is needed. So I'm going to walk you through
24 each of these.

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1 The second one before I get into detail is
2 the approach that I've used here to quantify a
3 66-bed need, which is why I'm comfortable that
4 there is the need for 60, and that approach, kind
5 of the gap-in-care approach, is consistent with
6 what I have used in other states for inpatient rehab
7 services that has been approved in multiple states,
8 and also the same methodology for other services,
9 again, that have been approved in other states
10 because you're trying to quantify that need.

11 There's two points I want to make about
12 your methodology. The first one, just to make
13 sure we're all on the same page, because you are
14 showing a bed need for 40 and we're proposing 60.
15 The historical utilization that is the basis for
16 the 40 beds is based on the hospitals within the
17 HSA, and that's important and is different than
18 basing it on the patients within the HSA.

19 And what I mean by that is the activity at
20 the hospitals is driving the utilization. So in
21 this instance where one-third of the patients are
22 leaving the community to go into Chicago for care,
23 your methodology doesn't capture that.

24 However, the second part of the methodology

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1 gives effect to if there's no beds and so low
2 utilization, you look at the statewide average,
3 and you apply that or allow the HSA to catch up to
4 the statewide average.

5 But here's the key. Your methodology only
6 has a 60 percent factor of that methodology -- a
7 60 percent factor of that rate, excuse me. So the
8 methodology says there's not -- historical
9 utilization is the basis, you're going to look to
10 the state average. But then for that HSA resident,
11 they only get to get part of the way to that
12 statewide average. They get a 60 percent factor,
13 not a hundred percent. That's how you get to a
14 bed need of 40, and I come in where I'm at 66 because
15 I am proposing as a health planner to close that
16 gap completely.

17 Are you all with me? Does that make
18 sense? Okay.

19 So the second approach is what I am
20 proposing. Again, it closes that gap completely.
21 It has two assumptions. One is that we will meet
22 a hundred percent of the need rather than only
23 60 percent as the State methodology, and, two is
24 that all patients within HSA 8 have equal access

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1 to care and that's key.

2 I'll get into detail in a minute, but the
3 bottom line is this. With limited beds in HSA 8,
4 if you are admitted to a general acute care hospital
5 with what we identify as a rehab appropriate
6 diagnosis, which goes to page 2 that's in your
7 handout, those categories, you have almost a
8 three times greater likelihood of being admitted
9 to rehab if your hospital has its own rehab unit
10 than if there is not one.

11 Several of you are with public health, and
12 you know with public health the concept is your
13 zip code should not dictate your success, whether
14 it's housing, food. This is similar. If you're
15 lucky enough to go into a hospital that has a rehab
16 unit, you can get discharged to a rehab program
17 when needed. If you go to a general acute care
18 hospital that does not have rehab, less likelihood
19 that you will get that care. So the approach I've
20 taken assumes -- I'm leveling the playing field
21 for all HSA 8 residents.

22 The third approach is -- I'll kick it back
23 to your rules, which is, what do the physicians
24 say? The first two approaches that both you have

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1 and I have is a quantitative assessment. You can
2 duplicate it with those sources or reference. But
3 the third is, what are the physicians kind of
4 boots on the ground telling you the need is?

5 And what they are saying and what they have
6 attested to in letters is over 1,000 referrals,
7 1,260 that justifies a 57-bed hospital. That is
8 based on their patients that they saw over a year
9 ago in 2018.

10 Though the rule doesn't allow it, the
11 reality is we know that population is growing and
12 we have to think about that. The staff report
13 references a 10.9 percent population growth for
14 the three counties. Simple math, if you multiply
15 the 57 beds times the population, you're at 63 beds.

16 So in all three scenarios if we close the
17 gap, you're above 60 beds. Are you all with me?
18 I threw out a lot of numbers and I apologize. I
19 don't know how else to do it.

20 If you look at page 5, this drills down
21 into the methodology that I have used here and in
22 other instances which gives you a graph and a
23 picture of so what; if you are telling me there's
24 too few beds, what does that mean? What it means

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1 is patients have access to service and their
2 utilization is less. Intuitively we know that.
3 This is a picture of it.

4 Just a few points. The graph shows
5 discharges per 1,000 Medicare beneficiaries, and
6 gives you a trend for that. If you look at the
7 bottom line that is Lake County, those are
8 discharges per thousand. For every 1,000 Medicare
9 persons in Lake County, only five have been
10 discharged from rehab in the last -- in the most
11 recent year. There are no beds in that county.

12 If you compare that to Kane County, which
13 is the orange line at the top, it is more than a
14 fourfold increase. 22 of those 1,000 patients
15 have access and have utilized inpatient rehab.
16 Kane County has two rehab providers. Lake County
17 with a very low and declining use has none.
18 McHenry has declined in their use rate. They now
19 have no beds, either. Their facility closed, as
20 well. I would expect that will continue to
21 decrease.

22 Are you all with me? Okay. Really not
23 much more.

24 Continuing with the gap in care approach

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1 that I have, without belaboring this, I do want to
2 walk you through it. There are two key
3 assumptions in this approach that quantifies the
4 need for 66 beds, and they're really the first
5 two lines.

6 One is from a 30,000-foot view, if you will,
7 we both know that not every patient that is
8 discharged from a general acute care hospital
9 needs rehab. There is only a subset of those
10 patients that can, as Dr. Talty said, undergo the
11 three hours of therapy and that need that care.

12 So the first line where you see around
13 41,000 discharges, those are patients who are
14 HSA 8 residents who have been discharged from
15 acute care who are rehab appropriate. To put it
16 in perspective, I took out 75 percent of the
17 patient discharges and ignored them; they're not
18 rehab appropriate.

19 So that gives you scale. So that's your
20 total potential patients or your rehab-appropriate
21 patients that should even be considered for
22 inpatient rehab. Of that, of those patients,
23 8.3 percent of patients with those diagnoses were
24 admitted to an inpatient rehab unit if that

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1 hospital had a rehab program. For the patients
2 who had the same diagnoses who went to a hospital
3 without it, 2.9 percent were discharged, a
4 threefold difference.

5 So the 8.3, what really happens if you go
6 where there's rehab beds, and you need the care
7 and you can access it became my baseline, so the
8 rest is simple math.

9 What's your total potential pool of
10 patients that are rehab appropriate? We expect
11 all patients to have equal access in HSA 8 if the
12 60-bed facility that is proposed is approved.
13 That gives you the number of rehab patients we
14 expect, minus how many occurred in the past gives
15 you the increment of 1,450. The 66 bed, I just
16 did not give you all the detail, it's based on a
17 14.1 length of stay and a 80 percent occupancy.

18 At this point, because I've said a lot of
19 numbers, do you have any questions or comments
20 before we shift to the third quantitative approach?

21 (No response.)

22 MS. CHAFIN: Okay. The third approach is
23 kind of kicking it back to you, is what the CON
24 rules require. And that is for -- let's set aside

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1 the analysis that's done at the 30,000-foot view
2 and go to boots on the ground.

3 21 physicians wrote referral letters and
4 testified that they would refer 1,260 patients.
5 Page 7 shows the patients' home zip codes, where
6 patients will come from. If you look at 7, the
7 red star is the proposed location. The 10-mile
8 radius is the geographic service area to make sure
9 there's no unnecessary duplication of service or
10 competing facility, and there's not in there. The
11 darker the zip code, the more patients from that
12 zip code who will be referred to the hospital,
13 and these are from the physicians' letters.

14 So, for example, Lake County, the home
15 county of the proposed facility represents 75 percent
16 of the referrals approximately; McHenry is another
17 20 percent. So as you would expect, approximately
18 95 percent of the referrals are coming from the
19 two northern counties where there are no rehab
20 facilities or no beds.

21 The only difference between page 7 and
22 page 8 is that page 8 has the distance. It has
23 the arrows that you can see to understand the
24 distance, which you know better than I do, it's

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1 almost an hour's drive to the closest rehab
2 provider in the service area, which is St. Joseph's,
3 it's 80 percent occupied; it's 37.8 miles away.
4 The farther facility is Copley Memorial at the
5 bottom of the map barely within the bottom Kane
6 County service, 75 minutes and 59 miles away.

7 So the purpose of this is to give you the
8 visual of the patient location, those patients
9 that will be referred and just reiterate that
10 there are no existing providers available.

11 If you don't have any questions, I'll turn
12 this over to Juan.

13 MR. MORADO: Thank you for making it with
14 us this far. We're in the home stretch. Marty,
15 thank you for your analysis. Appreciate that.

16 I'd just like to thank you all again and
17 give me an opportunity to summarize our
18 presentation for you and address those staff
19 report findings.

20 This project is the right size for this
21 community. It's not a project for 40 beds, and
22 it's not a project for 100 beds. As the Board
23 staff knows and this Board itself, the 100-bed
24 rule historically hasn't been based on any

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1 particular research or policy, and while we
2 understand that it is the rule, we appreciate the
3 Board's willingness over the years to use your
4 discretion to approve right-size projects that
5 provide needed services to a community.

6 I'd like to touch on the cost of the rehab
7 hospital. The costs of building a rehab hospital
8 are significantly different than what you might
9 see for an acute care. A lot of reason for that
10 is going to be the larger therapy and gym area.
11 The costs for this project are consistent with
12 what this Board has approved for other projects in
13 the northern Chicagoland suburbs, and while this
14 might be a concern for a project that has
15 questionable financing, that's not the case here.

16 You can see from your staff report that we
17 have met all the financial standards and that we
18 have ample resources available and committed to
19 complete this project.

20 I'd like to touch on next the clinical
21 space overage. There's a finding in the report
22 that the clinical space, which is the space in
23 which care is going to be provided to the
24 patients, is slightly over the Board standard.

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1 The amount that it's over is about the size of the
2 presentation tables that you're sitting at right
3 now. So we're not talking about a huge overage.

4 I'd like to point out, as referenced in
5 the application notes, that the patient rooms
6 themselves do, in fact, meet the Board standards,
7 and the overage in this case is clearly attributed
8 to the unique design of our hospital's therapy and
9 gym space that Ms. Brewer spoke to a little bit
10 earlier.

11 Finally, I'd like to touch on the last
12 two findings which touch on projected utilization
13 and service demand. Today you heard from Marty
14 Chafin. She educated us all on a couple different
15 points.

16 To start, we're all in agreement that
17 under the Board's need methodology there is a need
18 for 40 beds in HSA 8. And under the Board's rules
19 governing future need, we have provided evidence
20 that there's need for nearly every single bed
21 that's being requested in the hospital.

22 Finally, we used an alternative need
23 methodology that this Board has accepted as
24 recently as September for another project where we

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1 looked at rehabilitation inpatient quotas, that's
2 information that's on page 2, and discharge data
3 of patients who have received inpatient rehab
4 care, and that reflects a need for even more beds
5 than we are seeking in this application.

6 Your staff report correctly notes that we
7 have met the criteria associated with project need,
8 and there are no other services within 10 miles.
9 You only need to look at Slide No. 8 in your
10 packet and up there on the board to see just how
11 far the other two rehab units in the HSA are. You
12 have one that's about 39 miles away or an hour's
13 drive if you have good traffic, and the other
14 which is 59 miles away or a 75-minute drive.

15 We hope we provided you with ample
16 documentation for the need of this service in the
17 HSA and the evidence that's going to give you
18 comfort to use your discretion to approve this
19 project and fulfill your mission in ensuring we
20 provide access to necessary care that this
21 community needs.

22 We thank you for your consideration. We'd
23 be happy to answer any questions you have, and,
24 again, just want to point out that, as you heard

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1 from Dr. Talty, this type of care really can make
2 a difference in people's lives.

3 And so with that, thank you.

4 CHAIRWOMAN SAVAGE: So for our Board
5 members, do we understand the alternative needs
6 methodology that we're speaking of, and do we have
7 any questions about that specifically, or Mike or
8 George, too.

9 MEMBER MURRAY: I have a question not
10 about that methodology. I have a question for the
11 staff. In the State methodology used, in the
12 border areas, do we take account what's over the
13 border?

14 MR. CONSTANTINO: No, we don't do any
15 in-migration or out-migration in comprehensive
16 rehab. We do do it for medical surgical, though.

17 MEMBER MURRAY: Just not for this?

18 MR. CONSTANTINO: No.

19 MEMBER MURRAY: And then I remember some
20 previous meeting, but it was for an acute care
21 hospital, that the requirement to have at least
22 100 beds had been recently removed. Is that right?
23 It was for Provident, I believe.

24 MR. CONSTANTINO: No, Provident was a

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1 modernization project. That was the difference
2 with that. That rule is still in effect, the
3 100-bed rule.

4 MEMBER MURRAY: For building fresh?

5 MR. CONSTANTINO: Right.

6 MEMBER MURRAY: Then let me ask you all,
7 in your needs assessment did you look north of the
8 border? Do you have any comments about what's on
9 the other side of the border?

10 MS. CHAFIN: There is a facility about an
11 hour away in Wisconsin, and less than 1 percent of
12 the Medicare patients utilize that. They would go
13 to Chicago or forego the care based on the
14 physicians' letters.

15 MEMBER MARTELL: I have a follow-up
16 question really related to Methodology 3. Because
17 I know the staff Board report talked about that
18 the referral letters did not support the number of
19 patients more than they indicate were currently
20 being referred. Could you address that?

21 MS. CHAFIN: Yes. The physician letters
22 talk about the patients that were appropriate and
23 should have received the care that they intend to
24 refer to this program because there is a lack of

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1 beds. For example, two of the physicians
2 referenced specifically not in referral letters
3 but in their letters of support that they had
4 patients in need of the inpatient rehab, and they
5 instead got outpatient therapy.

6 So all of the patients that are projected
7 to be referred have not historically been referred.
8 It is more of a projection that these physicians
9 have attested to versus those patients receiving
10 it in the past.

11 MR. SILBERMAN: And with regards to the
12 number of referrals, the referrals that were
13 identified got us to the justification of, I
14 believe it was 57.3. So 58 beds, which was just
15 shy of the 60 that we were seeking. But based on
16 the testimony that you heard this morning from
17 Barb Martin, the need in the evaluation, it was
18 overwhelming for the need for services.

19 CHAIRWOMAN SAVAGE: Mike, do you have any
20 comments?

21 MR. CONSTANTINO: No, thank you.

22 CHAIRWOMAN SAVAGE: Okay. Seeing no other
23 questions or comments, I would ask for a roll call
24 vote, Mr. Roate.

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1 MR. ROATE: Thank you.

2 Motion made by Mr. Slater; seconded by
3 Dr. Murray.

4 Senator Demuzio.

5 MEMBER DEMUZIO: Yes, based upon the staff
6 report and the testimony that I've heard.

7 MR. ROATE: Thank you.

8 Dr. Martell.

9 MEMBER MARTELL: Yes, based on the
10 methodology that was explained today and the cost
11 overrun discussion.

12 MR. ROATE: Thank you.

13 Dr. Murray.

14 MEMBER MURRAY: Yes, based on the
15 application and the discussion today.

16 MR. ROATE: Thank you.

17 Mr. Slater.

18 MEMBER SLATER: Yes, based on the report
19 and the testimony.

20 MR. ROATE: Thank you.

21 Chairwoman Savage.

22 CHAIRWOMAN SAVAGE: I vote yes based on
23 the State Board staff report, the testimony, and
24 the fact that the reasonableness of cost, we're

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1 talking about a different methodology that is
2 understandable, but that's different than what we
3 normally do; the 100-bed rule, we talked about
4 that; the referral letters not stating because
5 they're based on projections, that made sense; and
6 the project rooms are bigger because of the
7 equipment that's in the room, so that's why I vote.

8 MR. ROATE: Thank you.

9 That's 5 votes in the affirmative.

10 CHAIRWOMAN SAVAGE: The motion is approved.
11 thank you.

12 So I think we would really like to work on
13 as a Board and the staff looking at these
14 different methodologies and research the 100-bed
15 rule specifically. So if we can start working on
16 that a little bit more, I think that would be
17 helpful.

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1 CHAIRWOMAN SAVAGE: Next on our agenda is
2 Item H-03, Project 19-043, Metroeast Endoscopic
3 Surgery Center in Fairview Heights. May I have a
4 motion to approve an addition of four surgical
5 specialties for Project 19-043, Metroeast
6 Endoscopic Surgery Center, Fairview Heights.

7 MEMBER DEMUZZIO: Motion.

8 CHAIRWOMAN SAVAGE: Second.

9 MEMBER SLATER: Second.

10 CHAIRWOMAN SAVAGE: Please identify
11 yourselves, spell your names, and be sworn in.

12 MS. FRIEDMAN: I am Kara Friedman, K-a-r-a
13 F-r-i-e-d-m-a-n. I'm with the law firm of
14 Polsinelli, which is P-o-l-s-i-n-e-l-l-i.

15 DR. AHMED: Shakeel, S-h-a-k-e-e-l; Ahmed,
16 A-h-m-e-d. I'm from Metroeast.

17 (Witnesses sworn.)

18 CHAIRWOMAN SAVAGE: Mr. Constantino, if
19 you could do the State Board staff report.

20 MR. CONSTANTINO: Thank you, Madam Chair.

21 The applicant is asking the State Board to
22 approve the addition of surgical specialties to an
23 existing ASTC at a cost of approximately \$331,000.
24 No public hearing was requested, and letters of

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1 support and opposition were submitted to the State
2 Board and are included at the end of this report.

3 The applicant addressed a total of
4 15 criteria and did not meet 3 of those criteria.
5 We did receive a comment on the State Board
6 staff report, and that was sent to you by email,
7 but a hard copy is here if you would like to
8 review it.

9 Thank you, Madam Chair.

10 CHAIRWOMAN SAVAGE: Thank you. If you
11 could please proceed with your statement, and be
12 sure to speak loudly.

13 DR. AHMED: Good morning. My name is
14 Shakeel Ahmed and I'm here representing Metroeast
15 Endoscopic Surgery Center. With me is Kara
16 Friedman of Polsinelli.

17 I'm pleased to be here today to request
18 permission to allow a broader variety of physician
19 specialists to be on staff at the surgery center.
20 I want to thank our community for the outpouring
21 of support we have received for this plan. I
22 particularly want to thank Mark Freeland for
23 speaking in support today. Mr. Freeland is the
24 executive director of Southern Illinois Regional

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1 Wellness Center, one of the FQHCs from which the
2 surgery center readily accepts referrals. Also,
3 over a dozen support letters were submitted to
4 this Board, including from State Representatives
5 Jay Hoffman and LaToya Greenwood. These
6 supporters identified many of the access problems
7 for residents of the Metroeast area, including
8 rising healthcare costs and financial ruin
9 experienced by people who get huge surprise
10 medical bills from hospitals.

11 In 2013 this Board approved the establishment
12 of our surgery center in the Metroeast area. If
13 you are unfamiliar, this is the area just across
14 the river from St. Louis.

15 When the initial CON application to open
16 the center was presented, this agency approved it
17 recognizing a need for a high-quality, low-cost
18 surgical option for the elderly and the less
19 affluent members of our community who need
20 endoscopy care that were essential to ensuring
21 their well-being, and particularly the early
22 detection of colorectal cancer. Colon cancer
23 screening and simple polyp removal saves so many
24 lives across our country and in this state, and it

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1 continues to be an essential part of the services
2 we provide. It also saves our economy millions of
3 dollars from avoiding costs to treat advanced and
4 often fatal cancer.

5 When I came before this Board in 2013, I
6 committed to serving as a safety net provider.
7 I'm proud to say that our Joint Commission
8 accredited surgery center has lived up to that
9 commitment and is the largest provider of Medicaid
10 ambulatory surgical treatment services for the
11 entire planning area HSA 11, which includes
12 Clinton, Madison, and St. Claire counties. During
13 the last four years, 26 percent of our patients
14 have been Medicaid beneficiaries, compared to
15 7.6 percent for the entire HSA 11 and 4.2 percent
16 statewide. In fact, over 60 percent of Medicare
17 beneficiaries treated at a surgery center in
18 HSA 11 were served by our small surgery center.
19 With an initial focus of colorectal screening and
20 other upper and lower GI services, with unanimous
21 approval of this Board we have since expanded our
22 focus to three other surgical specialties.

23 Today we seek permission to allow
24 podiatrists, pain management specialist, and eye

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1 surgeons on staff. The addition of these patients
2 at our center will help to fill the local void
3 left by the relocation of St. Elizabeth Hospital
4 from Belleville to O'Fallon and the shift of
5 services to Memorial Hospital Belleville to
6 Memorial Hospital East in Shiloh. Our center is
7 located in St. Claire County. Because of the lack
8 of healthcare resources, patients often must
9 travel to Missouri for simple elective lower cost
10 surgical procedures. Expanding our medical staff
11 would provide residents with a high-quality,
12 low-cost option to area hospitals without having
13 to leave the state.

14 The Medicare Payment Advisory Commission,
15 on MedPac advises congress on reimbursement issues
16 relative to Federal healthcare reimbursement
17 policy. According to its most recent 2019 report
18 to Congress, providing Medicare beneficiaries
19 access to freestanding surgery centers is
20 beneficial because services provided in an ASC
21 setting are, and I quote, "less costly to Medicare
22 and beneficiaries than services delivered in
23 hospital outpatient departments. Medicare payment
24 rates for surgical procedures performed in

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1 hospital outpatient departments are almost twice
2 as high as in ASCs," unquote.

3 Providing a lower cost alternative is
4 critical in these days of reduced access to
5 affordable employer-based health insurance. In
6 our gig worker economy, many people, if insured at
7 all, now have a \$5,000 or more deductible
8 regardless of their income level. With this
9 benefit structure, unless a patient experiences a
10 catastrophic illness, their insurance benefits are
11 generally irrelevant.

12 Further, according to Census Bureau data,
13 15 percent of residents live at or below the
14 Federal poverty limit. This is why I treat so many
15 Medicare patients. In hospitals, about 20 percent
16 of patients undergoing surgery receive a surprise
17 medical bill, which can be in excess of \$100,000.
18 We do not engage in the practice of surprise
19 medical building and advertise our rates for
20 people paying out of pocket in advance. We also
21 never send a patient's unpaid bill for collection.

22 As I mentioned earlier, this surgery
23 center serves a disproportionate number of
24 low-income patients and are acutely aware of how

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1 an excessive medical bill can devastate a family.
2 How many GoFundMe campaigns have you seen to cover
3 extraordinary medical expenses?

4 Unless and until there are affordable
5 health insurance options, the communities we serve
6 deserve a lower cost option. As previously noted,
7 we have historically treated 60 percent of
8 Medicaid beneficiaries receiving ASC service in
9 our planning area, but we also offer our uninsured
10 patients a global fee or free care if they cannot
11 afford it. We readily accept free clinical
12 referrals, and we stand behind our commitment to
13 continuing our practices as a safety net provider.
14 And as we add services, we'll increase access for
15 the underserved. We've been one since we opened
16 our doors six years now. That is a documented
17 track record that you can count on.

18 We're very proud of what we do for our
19 community and our patients. I ask that you
20 approve this application for additional surgical
21 specialties so we can provide a high-quality,
22 low-cost option to Metroeast residents.

23 Thank you for your time. I'm happy to
24 answer any questions.

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1 MS. FRIEDMAN: If I can just make a
2 comment before we entertain questions, I
3 appreciate that.

4 This application is to expand to allow
5 four different types of specialties to become
6 staff members at the surgery center. Due to the
7 opposition for adding orthopedic services that we
8 saw from one of the area hospitals, we would ask
9 that through some sort of condition process or
10 other mechanism that we delete orthopedics from
11 this application and go ahead with just the other
12 three.

13 There's another surgery center nearby in
14 Belleville that is closing, and some of those
15 specialists need to be able to stay in the
16 Belleville/Fairview Heights area and would want to
17 use the center, and we can think about orthopedic
18 at another day.

19 So at this point I think we'd be happy to
20 answer questions -- and we did speak to staff
21 briefly about that idea before the meeting. I'm
22 happy to discuss that part of it a little bit
23 further.

24 MS. ALIKHAN: Thank you. I just wanted to

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1 say that I don't think, due to the removal of the
2 orthopedic services, that we would need to issue a
3 conditional permit. We could simply amend the
4 motion.

5 MEMBER MURRAY: I have a question.

6 CHAIRWOMAN SAVAGE: Go ahead.

7 MEMBER MURRAY: On our agenda it says
8 there's no opposition. Is that wrong?

9 MR. CONSTANTINO: That's incorrect. There
10 was opposition to this project. HSHS, the two
11 hospitals that they own down in southern Illinois
12 oppose the project.

13 MS. FRIEDMAN: If I may, Mike, I believe
14 they specified their objections around orthopedic.

15 CHAIRWOMAN SAVAGE: Other questions?

16 MEMBER MURRAY: So are you all officially
17 changing your application now to remove ortho?

18 MS. FRIEDMAN: That's right. We tried to
19 coordinate that with counsel before the meeting.
20 So we'd only be adding three specialists with this
21 application.

22 If I may, it's an ongoing -- we can always
23 reassess orthopedics at a later date and file a
24 new application.

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1 CHAIRWOMAN SAVAGE: Well, I do have one
2 question as it relates to the maldistribution and
3 duplication.

4 So there is a facility that's not yet open
5 that has many of these services. So how will that
6 affect the community hospitals in the community in
7 your area when that actually becomes open in addition
8 to your facility if it were approved -- or your
9 beds rather?

10 MS. FRIEDMAN: Well, I do believe that the
11 project that you're referring to was a transition
12 of hospital services to ambulatory services, and
13 in connection with that application they identified
14 a different set of patients that would be
15 referring to that facility that are not involved
16 in this project. So I don't think it would affect
17 it, and it is in another county 17 miles away.

18 CHAIRWOMAN SAVAGE: Okay. Any other
19 questions, concerns?

20 (No response.)

21 CHAIRWOMAN SAVAGE: Okay. Well, hearing
22 no other, if I could ask for a roll call vote,
23 Mr. Roate.

24 MR. ROATE: Thank you, Madam Chair.

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1 Motion made by Senator Demuzio; seconded
2 by Mr. Slater.

3 CHAIRWOMAN SAVAGE: Hold on, I have to
4 amend the motion.

5 So may I have a revised motion to approve
6 an addition of three surgical specialties,
7 podiatry, pain management, and ophthalmology.

8 MEMBER SLATER: I would withdraw my motion
9 subject to excluding orthopedic services.

10 CHAIRWOMAN SAVAGE: So, again, may I have a
11 motion to approve now an addition of three surgical
12 specialties for Project 19-043, Metroeast
13 Endoscopic Surgery Center Fairview Heights for the
14 specialties of podiatry, pain management, and
15 ophthalmology.

16 MEMBER SLATER: Yes.

17 CHAIRWOMAN SAVAGE: And a second.

18 MEMBER DEMUZIO: Second.

19 CHAIRWOMAN SAVAGE: Now, Mr. Roate,
20 roll call.

21 MR. ROATE: Thank you, Madam Chair.

22 Motion made by Mr. Slater; seconded by
23 Senator Demuzio.

24 Senator Demuzio.

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1 MEMBER DEMUZIO: Yes, based upon the staff
2 report and the testimony today.

3 MR. ROATE: Thank you.

4 Dr. Martell.

5 MEMBER MARTELL: Yes, based on the staff
6 report and removal of orthopedics.

7 MR. ROATE: Thank you.

8 Dr. Murray.

9 MEMBER MURRAY: Yes, based on the revised
10 application and the staff report.

11 MR. ROATE: Thank you.

12 Mr. Slater.

13 MEMBER SLATER: Yes, based on the staff
14 report and the testimony.

15 MR. ROATE: Thank you.

16 Chairwoman Savage.

17 CHAIRWOMAN SAVAGE: Yes, based on the
18 testimony and staff report.

19 MR. ROATE: Thank you.

20 That's 5 votes in the affirmative.

21 CHAIRWOMAN SAVAGE: So the motion is
22 approved. Thank you.

23 MS. FRIEDMAN: Thank you very much.

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1 CHAIRWOMAN SAVAGE: Next on the agenda,
2 Item H-04, Project 19-044, Dialysis Care Center of
3 Rockford.

4 May I have a motion to approve an
5 establishment of an 8-station ESRD facility for
6 Project 19-044, Dialysis Care Center of Rockford
7 in Rockford.

8 MEMBER DEMUZIO: Motion.

9 CHAIRWOMAN SAVAGE: Second.

10 MEMBER MURRAY: Second.

11 CHAIRWOMAN SAVAGE: Please identify
12 yourselves, spell your names for the reporter, and
13 be sworn in.

14 DR. SALAKO: My name is Dr. Babajide Salako,
15 B-a-b-a-j-i-d-e; last name S-a-l-a-k-o, CEO of
16 Dialysis Care Center.

17 MR. AZAM: Good morning. My name is
18 Salman, S-a-l-m-a-n, last name A-z-a-m. I'm
19 general counsel for Dialysis Care Center.

20 MS. SMITH: My name is Melissa Smith. I
21 am director of operations with Dialysis Care
22 Center, S-m-i-t-h.

23 MS. ZEPEDA: Good morning. My name is
24 Alejandra Zepeda. I am the clinical manager of

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1 Rockford. It's A-l-e-j-a-n-d-r-a Z-e-p-e-d-a.

2 MR. SHAZZAD: Good morning, Asim Shazzad,
3 A-s-i-m; last name Shazzad, S-h-a-z-z-a-d, chief
4 operating officer for Dialysis Care Center.

5 DR. MAHMOOD: Good morning, Talal Mahmood,
6 T-a-l-a-l M-a-h-m-o-o-d, nephrologist with
7 Dialysis Care Center.

8 (Witnesses sworn.)

9 CHAIRWOMAN SAVAGE: Mr. Constantino, if
10 you could please give the State Board staff report.

11 MR. CONSTANTINO: Thank you, Madam Chair.

12 The applicants are asking the State Board
13 to approve the establishment of an 8-station ESRD
14 facility in Rockford, Illinois. The cost of the
15 project is approximately \$1.1 million, and the
16 expected completion date is December 31st, 2021.

17 Public hearing was held on this project on
18 February 7, 2020. Opposition comments were
19 received by the State Board staff, and we also
20 received a comment on the State Board staff report
21 which was emailed to you. I do have hard copies
22 here if you'd like to review that.

23 The applicants addressed 21 criteria and
24 did not meet 3 criteria.

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1 Thank you, Madam Chair.

2 CHAIRWOMAN SAVAGE: Thank you.

3 Please proceed.

4 DR. SALAKO: Thank you, Madam Chair. I
5 will divide this testimony into three parts. The
6 first item my clinical staff will talk about the
7 dialysis program of Rockford and the need for a
8 dialysis clinic, we will address the negative
9 findings on the report, and then finally, I will
10 conclude by talking about the opposition to the
11 project and why we want the Board to approve our
12 project.

13 So I'd ask Dr. Mahmood to start.

14 DR. MAHMOOD: So I'm going to be talking
15 in support of the DCC clinic. As we know, DaVita
16 is the sole provider of in-center dialysis in the
17 Rockford area, and they have a monopoly there.
18 They can provide whatever kind of care to the
19 patients, and patients have to tolerate that as
20 they do not have any other choices in the area.
21 The dissatisfaction in care can lead to compliance
22 issues, which can cause problems with overall
23 well-being of the patient.
24 The closest in-center dialysis facility other

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1 than DaVita to Rockford is about 40 to 50 miles
2 from Rockford, and there has been instances where
3 patients have to travel that far in order to get
4 this life-sustaining treatment.

5 Imagine end stage renal disease is already
6 a life-changing diagnosis, and if you have to travel
7 that far for that life-sustaining treatment, it is
8 a burden for patients and their families.
9 Therefore, I think the patients in Rockford area
10 should have this option close to home.

11 Also, quality of care provided by any
12 provider improves if there is competition in the
13 area. As a physician, I do not have any voice
14 inside the office of DaVita. Therefore, I would
15 like to work in a facility which is owned and
16 managed by physicians so that I can be part of
17 operations, quality, and staffing and can provide
18 best possible care for the patients in Rockford.

19 I think we seek your approval for the
20 patients of the Rockford area. Thank you.

21 MS. ZEPEDA: Good morning. My name is
22 Alejandra Zepeda, and I'm a registered nurse and
23 home program clinical manager. I've worked closely
24 with Dr. Mahmood and Dr. Manda for the last five

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1 years, and in the last three years I have been
2 directly involved with the census growth, patient
3 satisfaction, and transitioning to the home setting.

4 We at Dialysis Care Center assist our
5 patients through many stages while we educate for
6 the home program. These patients do not just look
7 at us like another staff member in a clinic. We
8 provide our patients a more personal relationship
9 with their dialysis care. We can provide the
10 patient that same care team and the culture offered
11 in the program. By allowing them the opportunity
12 to transfer into a program monitored and built
13 upon that same culture, patients will experience
14 less stress and increased patient compliance.
15 This continuity of care improves patient
16 satisfaction and outcomes, which benefits the
17 community as a whole.

18 Being given the opportunity to open an
19 incenter would allow our patients to have a choice
20 in their dialysis provider once they are no longer
21 able to perform dialysis at home. Along with
22 being able to stay with their provider, the
23 patients are allowed to keep their whole care
24 team: Nurses, technicians, dieticians, and social

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1 workers.

2 Our patients want to stay with us. They
3 prefer to stay with us. They either drive to
4 Elgin or Crystal Lake just because they know what
5 kind of care they will receive. Just imagine from
6 the start of your dialysis you have worked with
7 the same group of people, and now you are no
8 longer able to continue with them due to
9 unforeseen events. Here you are in a different
10 clinic, with different people and a different way
11 of communication and no longer seeing those
12 familiar faces you're see used to seeing.

13 Allowing Dialysis Care Center to open a
14 chronic center will improve every dialysis patient
15 care for Rockford and the surrounding area. I'm
16 sure you're asking what I mean by this. I'm
17 referring to the patient satisfaction rating. We
18 want to make the dialysis experience easy and make
19 patients feel comfortable. If there's only one
20 business providing dialysis, there's nothing for
21 patients to compare it with and nowhere else to
22 go. DCC coming into the picture, again, will give
23 the patients more options, choices, and be able to
24 compare things. Allowing DCC in Rockford will

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1 give the only other dialysis center in the area
2 some competition, and they will have to improve
3 their patient satisfaction rating, meaning all
4 patients will get better care, not just DCC patients.

5 Thank you guys for your time and
6 consideration.

7 MS. SMITH: My name is Melissa Smith. I'm
8 director of operations for Dialysis Care Center,
9 and I'm also a home therapy nurse.

10 As our company continues to grow, we have
11 seen an increased need to provide transitional
12 care to both incoming and current home dialysis
13 patients.

14 Transitional care is important for new
15 home patients that may need short-term hemodialysis
16 while they stabilize before training and for
17 current home patients that need temporary
18 hemodialysis after surgeries or other illnesses
19 that require them to take a break from home
20 therapy. The goal for all of these patients is to
21 go back to home therapy.

22 Although our company's foundation is built
23 on home therapy, as our population grows it's
24 become a growing concern that we are unable to

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1 provide quality transitional care to our patients
2 without any incenter services. This has a direct
3 impact on the continuity of care that our patients
4 and their families deserve to have.

5 Unfortunately, without the opportunity to
6 have a DCC incenter for our transitional patients
7 to utilize in the Rockford area, we are unable to
8 provide them with the culture of care that they're
9 accustomed to in our home programs, and they are
10 forced to go to other providers during this
11 transitional time.

12 I have personally experienced the positive
13 impact that our DCC in-centers have had on
14 transitional care patients in other units that I
15 oversee. I have seen an improvement in patients'
16 understanding of home therapy and a decreased
17 level of patient confusion during the transition
18 process. The improvements that I have witnessed
19 are a direct result our care team being able to go
20 into the DCC units to sit down and have personal
21 face-to-face discussions with patients and to
22 answer their questions and calm their fears prior
23 to transferring over to the home program.

24 We cannot enter into units that are not

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1 owned by DCC to have these personal one-on-one
2 interactions with the patient. It is unfortunate
3 that only one company is given the chance to offer
4 this valuable transitional service in the Rockford
5 community. Patients and their families deserve to
6 have a choice in providers and should not be
7 forced to utilize only DaVita for their dialysis
8 needs or else to drive over an hour away to other
9 DCC units. While patients didn't choose to get
10 kidney disease, they should get a choice about who
11 gives them care.

12 By giving DCC the opportunity to provide
13 transitional care patients a hemodialysis option
14 with their current dialysis provider, we will be
15 able to improve the continuity of care and the
16 quality of care which, ultimately will affect the
17 most important people in this discussion, the
18 patients.

19 Thank you.

20 MR. AZAM: Good morning, Madam Chair,
21 Members of the Board. My name is Salman Azam.
22 I'm general counsel of Dialysis Care Center, and
23 my talk will be focusing on the reasons for
24 noncompliance as stated in the report.

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1 The first one is a planning area need.
2 And our rationale to address the planning area need
3 is going to be revolving around the central theme
4 that we're talking about, the monopoly, the dangers
5 of the monopoly and how they affect everything and
6 every process of care here in this area and also
7 the planning area need.

8 The calculated need is now at 5 stations,
9 and our application is for 8 stations. And to
10 kind of explain how this came about, I'm going to
11 give a slight historical perspective going back to
12 third quarter of 2019 when the need was seven.

13 Dialysis Care Center relied upon this
14 posting of a need of seven, and we made an
15 application for seven plus one chair for isolation,
16 the eight chairs. The eight chairs also resonates
17 with the Joint Committee of Administrative Rules
18 administrative code. I'll just remind the Board of
19 Title 77, Chapter II, Subchapter A, Section 1110-230,
20 in the establishment of services for Facility G,
21 the minimum number of stations for an incenter
22 hemodialysis renal facility is eight within the
23 MSA, and that is what Rockford falls in.

24 So we have a need of five, and we need

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1 eight to have another provider, and this is where
2 we have to discuss the issue of the monopoly, of
3 the only game in town. Our physicians, our
4 clinical team have told you the undue burden the
5 patients of Rockford are undergoing when they want
6 continuity of care with their providers. They're
7 traveling as far as Crystal Lake or Elgin, and
8 this is not only an undue burden but a quality of
9 life issue for patients who are already undergoing
10 a lot of inconvenience, and we don't want that to
11 be the case.

12 The CON is supposed to control healthcare
13 costs and increase access to healthcare. We are
14 focusing on the access to care. We want our
15 patients, we want the patients in Rockford to have
16 access to care, and have quality care, and have
17 choices to that access of care, something they
18 lack right now.

19 The basic tenet of the CON regulation is
20 that excess healthcare facility capacity results
21 in healthcare price inflation. Okay? But another
22 thing that also results in healthcare price
23 inflation is if we or the CON Board allows only
24 one provider in an HSA or an entire MSA of

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1 Rockford.

2 Like the doctor had told you, when there's
3 no competition, prices can inflate and quality of
4 care can decrease, and the only people who suffer
5 in this are the patients of Rockford. And
6 Dialysis Care Center does not want to let that
7 happen.

8 So that is why we have eight in our
9 application is because we necessitate eight in the
10 application, and in order to have another provider
11 in Rockford, we need to have eight chairs approved
12 because there's no other way.

13 This process will keep continuing because
14 what happens -- DaVita has already also been given a
15 blanket approval for so many chairs in the Rockford
16 area. Every two years they're allowed to add
17 two more, and that's precisely what happened here.
18 There was a need for seven. I'm told DaVita has
19 added two in December of 2019, and that's why we
20 are at five.

21 If this process continues, no other provider
22 will actually ever have a good shot at entering
23 this market because the process and the numbers
24 can be continually manipulated in order to keep

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1 other providers and other access to care out of
2 this HSA.

3 Second, we talk about unnecessary
4 duplication of services and maldistribution. When
5 we look at -- when we look at here, the current
6 capacity of patients doesn't address the fact of
7 something that we already talked about here. We
8 have a number of our own patients going outside
9 this HSA because they want continuity of care.
10 This is a growing number. Okay? This number is
11 not reflected in the maldistribution that we're
12 talking about. If patients are leaving the HSA,
13 they're not being counted in the utilization, and
14 we want you to think about this. This could be
15 the number that have traveled outside Rockford,
16 whether it's Elgin or Crystal Lake, in order to
17 seek care, that number has only increased, and
18 that will adversely affect the utilization and
19 also the duplication of service and
20 maldistribution.

21 But, again, if we don't -- if we don't
22 allow a new provider to come in, if we don't
23 allow -- at this point I want the Board to be
24 proactive, not reactive. When we recently hear

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1 about monopolies, something comes to mind. You
2 know, we all have cell phones. Sprint and
3 T-Mobile came together and wanted to merge. They
4 first had to go through antitrust approval. We
5 don't have that kind of situation here. We already
6 have a monopoly in Rockford. DaVita has that
7 monopoly and they are dictating, and what I'm
8 trying to show you is they're also manipulating
9 the process in order to stay the sole provider in
10 Rockford.

11 We need to be proactive here. We need to
12 allow Dialysis Care Center and our patients who
13 have spoken not only this morning to tell you how
14 they want to keep their continuity of care, they
15 also came out and they spoke at the public hearing
16 in Rockford, I'm told you'll have a transcript of
17 that, where they very vehemently and passionately
18 spoke about how necessary it is to have a choice
19 of care, that they don't want to be forced to go
20 into the only game in town.

21 And I think this is the danger. We have --
22 we have a responsibility to our patients, and we
23 have a responsibility that they deserve the very
24 best care, and we know that this cannot be

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1 accomplished if we have one sole provider who is
2 calling all the shots and is able to manipulate
3 the process in order to continue their monopoly
4 and their service.

5 So thank you and I'm going to hand it over
6 to our director of operations to discuss the last,
7 the reasonableness of the project.

8 MR. SHAZZAD: Good morning -- or good
9 afternoon rather. I'm going to talk about where
10 the site is located. According to the HPSA it's
11 located in an low-income area. And the reasonable
12 cost, we did find a preexisting building that we
13 are currently utilizing for this project. Our
14 total costs are much, much lower than a new
15 construction project. Accordingly, the
16 engineering and remodeling costs are also lowered.
17 However, the engineering fees are usual and
18 customary to any dialysis unit that was found.

19 Thank you.

20 DR. SALAKO: To the Chairman of the Board
21 and Board members and faculty, you've heard
22 clearly why we want to have the clinic, we've
23 addressed the findings on the State agency report,
24 and we have also articulated the opposition to our

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1 project by DaVita.

2 I would like to stress again that in the
3 next applications after ours that the Board will
4 hear today will be for those who are opposing our
5 project but who want to expand the number of
6 chairs that they have. We just simply want to say
7 we want the Board to promote access to care, we
8 want the Board to promote options of care for the
9 patients, and we do not want the Board to find
10 itself as a tool of antibusiness activities.

11 We'll take any questions that you may have for us.

12 CHAIRWOMAN SAVAGE: Can you address the
13 cost for the architectural and engineering fees in
14 more detail, please.

15 MR. SHAZZAD: So the total cost of our
16 project is 1.1 million, which is far less than the
17 construction of most common dialysis units. The
18 reason why is because we found a preexisting
19 building that we're utilizing in a low-income area.

20 The 45,000 is a usual and customary
21 engineering and architectural fee that we have
22 seen that are costs on existing projects. It is --
23 the percentage -- the calculation is based on a
24 percentage of a total amount. So if our cost was

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1 \$2 million for a complete project, the engineering
2 fees of 45,000 will be usual, but since our complete
3 total cost is lower, that 45,000 is high, and it's
4 based on a percentage that the Board uses.

5 CHAIRWOMAN SAVAGE: Board members, any
6 questions?

7 Mike, any questions?

8 (No response.)

9 CHAIRWOMAN SAVAGE: Okay. Seeing no
10 questions -- or hearing no questions, Mr. Roate,
11 if you could do the roll call.

12 MR. ROATE: Thank you, Madam Chair.

13 Motion made by Senator Demuzio; seconded
14 by Dr. Murray.

15 Senator Demuzio.

16 MEMBER DEMUZIO: Yes, based upon the staff
17 report and testimony.

18 MR. ROATE: Thank you.

19 Dr. Martell.

20 MEMBER MARTELL: Yes, based on staff
21 report but concerns regarding construction cost.

22 MR. ROATE: Thank you.

23 Dr. Murray.

24 MEMBER MURRAY: Yes, based on the

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1 testimony and the staff report.

2 MR. ROATE: Thank you.

3 Mr. Slater.

4 MEMBER SLATER: Yes, based on the
5 testimony and the staff report.

6 MR. ROATE: Thank you.

7 Chairwoman Savage.

8 CHAIRWOMAN SAVAGE: Yes, based on the
9 testimony and staff report regarding especially
10 the project costs.

11 MR. ROATE: Thank you.

12 That's 5 votes in the affirmative.

13 CHAIRWOMAN SAVAGE: That motion is
14 approved.

15 So we are now going to go to lunch. So
16 the lunch will be approximately 45 minutes, and
17 we'll see you back at that time.

18 (Recess taken, 12:00 p.m. to 1:00 p.m.)

19 - - -

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1 CHAIRWOMAN SAVAGE: Welcome back everyone.

2 All right. So we're going to begin again
3 with Item H-05, Project 19-050, DaVita Freeport
4 Dialysis. May I have a motion to approve a
5 relocation and downsize to a 10-station ESRD
6 facility for Project 19-050, DaVita Freeport
7 Dialysis.

8 MEMBER SLATER: Motion.

9 CHAIRWOMAN SAVAGE: Second.

10 MEMBER MARTELL: Second.

11 CHAIRWOMAN SAVAGE: Please identify
12 yourselves and be sworn in unless you already
13 have been.

14 MS. FRIEDMAN: As a clarification, it's
15 going to be an eight-station facility.

16 I'm Kara Friedman with Polsinelli. With
17 me are Lynanne Hike of DaVita, as well as her
18 colleague, Mary Anderson, Dr. Murdakes, who is a
19 nephrologist that's involved in the facilities in
20 the Chicago area, and my colleague Anne Cooper
21 from Polsinelli.

22 (Witnesses sworn.)

23 CHAIRWOMAN SAVAGE: Mr. Constantino, if
24 you can give us the State Board staff report.

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1 MR. CONSTANTINO: Thank you, Madam Chair.
2 The applicants are asking the State Board
3 to discontinue DaVita Freeport Dialysis, a
4 10-station located in Freeport, Illinois, and
5 establish DaVita Alpine Dialysis in Rockford, an
6 eight-station facility. The cost of the project
7 is approximately \$3.5 million, and the expected
8 completion date is March 31st, 2022. The
9 applicants have addressed a total of 22 criteria
10 and failed to meet 3 criteria. There was a
11 comment on the State Board staff report that was
12 emailed to you. If you would like to review it, I
13 do have hard copies.

14 Thank you, Madam Chair.

15 CHAIRWOMAN SAVAGE: Thank you.

16 Okay. Please proceed with your statement
17 to the Board.

18 MS. HIKE: Good afternoon. First, this
19 project is unopposed and I'd like to thank Mayor
20 Thomas McNamara and SwedishAmerican Hospital for
21 their important community support of this project.
22 I'd also like to thank the Board staff for their
23 thorough review of this project and the generally
24 positive State Board staff report. I will touch

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1 on slight deviations from full compliance with the
2 applicable criteria in a moment.

3 This project will address the maldistribution
4 of dialysis stations within HSA 1, which is a very
5 large planning area by relocating eight stations
6 from our underutilized Freeport dialysis clinic to
7 South Rockford where there is currently no
8 dialysis clinic but a need for this service. In
9 fact, the need for stations in this county rather
10 than other more outlying areas of this health
11 planning area has been documented by your staff as
12 reflected on this map which shows the need in
13 excess by county.

14 MS. COOPER: As Annie noted, this map
15 actually shows the planning area stations and also
16 where the residents live. The areas that are
17 highlighted in blue are areas where there's an
18 excess of stations, and the areas that are in red
19 identify areas where there's a need for stations.
20 The darker the color, the higher the need.

21 What this project proposes, as Annie just
22 said, is to relocate stations from Stevenson
23 County, which is here, to Rockford. So this will
24 address the maldistribution of stations, as well

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1 as the Board's projected need for stations in this
2 area in 2022. So what DaVita's doing is really
3 appropriate health planning for this area.

4 MS. HIKE: As I previously indicated, we
5 plan to relocate eight stations to South Rockford.
6 For those members of the Board who are not
7 familiar with Rockford, Rockford was a thriving
8 city until the 1970s when manufacturing companies
9 started closing, and the heavily blue-collar
10 population faced high unemployment. Rockford now
11 has one of the highest unemployment rates in the
12 state. Roughly 80 percent of the students in the
13 Rockford public school system come from low-income
14 families, and educational attainment is
15 disproportionately low. Unfortunately, it has
16 been regularly ranked at the bottom of the rung
17 among 300 US cities in terms of quality of life.
18 Along with unemployment, lack of access to quality
19 healthcare, education, housing, and high crime
20 rate are all areas factors affecting quality of
21 life in Rockford.

22 As for the area we are seeking to locate
23 kidney care services, South Rockford is one of the
24 more economically disadvantaged areas with 9 percent

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1 of residents living in extreme poverty and 20 percent
2 of residents living below the Federal poverty
3 limit, compared to 6 percent of residents statewide
4 living in extreme poverty and 13 percent living
5 below the Federal poverty limit. Further, nearly
6 40 percent of the community members are either
7 black or Hispanic.

8 A unique characteristic of kidney disease
9 and its primary comorbidities of diabetes and
10 hypertension is that it negatively affects these
11 populations. Also, economic status is also tied
12 to higher morbidity and mortality generally and
13 relative to kidney disease. African-Americans,
14 Hispanics, and low-income individuals are
15 disproportionately affected by kidney failure.
16 According to the most current data, African-Americans
17 are 3.5 times more likely to develop ESRD than
18 Caucasians, and Hispanics are 1.5 times more
19 likely to develop ESRD than non-Hispanics. As for
20 income-based disparities within the African-American
21 community, individuals with income less than
22 \$20,000 are three times more likely to develop
23 ESRD than those earning over 75,000.

24 DaVita accepts and treats patients with

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1 renal failure needing dialysis without regard to
2 ability to pay. In fact, the payor mix for our
3 Rockford dialysis facilities is only 6 percent
4 commercial patients. The remaining patients are
5 either enrolled in Medicare or Medicaid as their
6 primary insurer. Compare this to the statewide
7 average payor mix for outpatient hospital
8 services, which is over 20 percent commercial
9 cases. With DaVita's patient admission policy
10 accepting all patients regardless of the ability
11 to pay, this proposed dialysis clinic will ensure
12 access to dialysis services for residents in South
13 Rockford.

14 As for State Board's negative findings,
15 there is a calculated need for five stations in
16 HSA 1. This project proposes the discontinuation
17 of an underutilized 10-station dialysis clinic in
18 Freeport and the establishment of an eight-station
19 dialysis clinic in Rockford where stations are
20 needed. Importantly, this proposed project will
21 not create an excess of stations in HSA 1 and will
22 actually return 2 stations to the Board's inventory.

23 We determined a need for dialysis service
24 exists in South Rockford based upon current

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1 utilization coupled with the progression of
2 patients diagnosed with chronic kidney disease who
3 are currently under a nephrologist's care.
4 Importantly, it does not take into account
5 undiagnosed patients. The prevalence of "crash"
6 starts in this area -- which are unplanned
7 dialysis starts initiated at the hospital on an
8 emergency basis -- is high. Many patients with
9 kidney failure "crash" onto dialysis. That is
10 they have no nephrologist prior to dialysis and
11 initiate dialysis in an unplanned fashion. When
12 this happens, a patient does not start dialysis
13 with a chosen modality; he or she starts with a
14 dialysis catheter rather than a fistula and often
15 requires hospitalization. Unplanned dialysis
16 starts are associated with both increased patient
17 morbidity and mortality and lower quality of life
18 scores.

19 As Board staff knows, DaVita's preliminary
20 plans to develop this clinic began several years
21 ago. DaVita continually monitors the utilization
22 at area facilities. Once utilization reached
23 65 percent in Rockford, DaVita began identifying
24 areas for an additional small clinic based on zip

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1 codes of residents of its existing dialysis
2 patients who don't otherwise have access to care
3 in their immediate community. To make services
4 most readily accessible, DaVita tries to locate
5 its clinics in the center of where patients reside
6 given that the regular course requires 156 clinic
7 visits per year. As a small eight-chair clinic
8 operating at target utilization it will have a
9 regular census of only 38 patients at any given time.

10 Thank you for your time and attention. I
11 respectfully request the Board to approve our
12 project to relocate eight stations from Freeport to
13 South Rockford. I am happy to answer any questions.

14 MS. FRIEDMAN: If I could just ask,
15 earlier at the beginning of the meeting someone
16 was talking about the difficulties of receiving
17 dialysis care, or I should say more broadly
18 chronic disease care as a patient, and I would ask
19 that Dr. Murdakes could just explain a little bit
20 about that subspecialty of medicine.

21 DR. MURDAKES: Pediatric patients generally
22 are taken care of by pediatricians, and those of
23 us in the Rockford area are board certified in
24 internal medicine and nephrology, and we are only

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1 able to take care of adults. As a result, most of
2 our pediatric patients are seen outside of our
3 area and receive their care like at UW or the
4 Chicagoland area, and most of them are on home
5 modalities for that reason. That's actually
6 something that's out of the scope of our practice.

7 CHAIRWOMAN SAVAGE: Any questions from our
8 Board members?

9 (No response.)

10 CHAIRWOMAN SAVAGE: Mike or George, do you
11 have any questions?

12 (No response.)

13 CHAIRWOMAN SAVAGE: So I guess my concern
14 would be the seven facilities in the area that are
15 underutilized. So that's in your current area
16 where you're closing the facility. The one that
17 you want to move, that's where the need is, if I'm
18 understanding what you're saying right. Is that
19 correct?

20 MS. FRIEDMAN: There are two approved
21 facilities in Freeport, and so this would be
22 consolidating all the patients into one in
23 Freeport and taking those needed stations to the
24 county where a need has been identified.

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1 CHAIRWOMAN SAVAGE: When you calculated
2 your patients, are these the same patients at the
3 Freeport location that are going to go to Rockford?

4 MS. FRIEDMAN: No, the patients at the
5 Freeport clinic are moving to the other Freeport
6 clinic. They're not going to be traveling to
7 Winnebago County. These are chronic kidney
8 disease patients who are in the later stages of
9 the disease.

10 MEMBER SLATER: Why has the Freeport
11 facility been so underutilized recently?

12 MS. FRIEDMAN: Mary, do you want to speak
13 to that?

14 MS. ANDERSON: In Freeport we offer home
15 dialysis, so a significant number of patients are
16 at home, and we no longer need 20 stations in the
17 Freeport market. It's a smaller community that
18 doesn't support a 20-station facility. We have
19 10 at one and 10 at the other for a total of 20.

20 MEMBER MARTELL: Can you kind of share
21 some of the information on the utilization rate of
22 your other sites in Rockford.

23 MS. FRIEDMAN: Can you repeat the question
24 a little bit louder?

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1 MEMBER MARTELL: Can you respond to the
2 utilization of your other dialysis centers in
3 Rockford?

4 MS. HIKE: The Stone Crest facility, which
5 is the closest facility nearest to the one we are
6 asking for is currently operating at 100 percent,
7 and it has been for the past three or four years.
8 The next nearest facility then is Roxbury, and
9 that is operating at 88 percent, and then Churchview
10 which is operating at 65 percent capacity. We do
11 have a newer facility in Forest City, and that is
12 currently about 40 percent capacity, but it's not
13 located near where we're asking to put our new
14 facility, which is South Rockford.

15 MS. COOPER: Part of the reason for this
16 project is to alleviate the overutilization of that
17 Stone Crest facility, which is about 2 miles away.

18 CHAIRWOMAN SAVAGE: Other questions or
19 comments by the Board or staff?

20 (No response.)

21 CHAIRWOMAN SAVAGE: Okay. Hearing or
22 seeing none, I would ask for a roll call vote from
23 Mr. Roate.

24 MR. ROATE: Thank you, Madam Chair.

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1 Motion made by Mr. Slater; seconded by
2 Dr. Martell.

3 Senator Demuzio.

4 MEMBER DEMUZIO: Yes, based upon the staff
5 report but also the explanation and the clear and
6 precise answers to the questions. So yes. I
7 vote yes.

8 MR. ROATE: Thank you.

9 Dr. Martell.

10 MEMBER MARTELL: Yes, based on staff
11 report and the testimony.

12 MR. ROATE: Thank you.

13 Dr. Murray.

14 MEMBER MURRAY: Yes, based on the
15 testimony and staff report.

16 MR. ROATE: Thank you.

17 Mr. Slater.

18 MEMBER SLATER: Based on staff report and
19 testimony, yes.

20 MR. ROATE: Thank you.

21 Chairwoman Savage.

22 CHAIRWOMAN SAVAGE: Yes, based on staff
23 report and testimony.

24 MR. ROATE: Thank you.

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1 CHAIRWOMAN SAVAGE: Next, Item H-05,
2 Project 19-055, DaVita Forest City Dialysis in
3 Rockford. May I have a motion to approve an
4 addition of 4 ESRD stations for Project 19-055,
5 DaVita Forest City Dialysis Rockford.

6 MEMBER DEMUZIO: Motion.

7 CHAIRWOMAN SAVAGE: Second.

8 MEMBER SLATER: Second.

9 CHAIRWOMAN SAVAGE: And you don't need to
10 introduce yourselves again.

11 Mr. Constantino, your staff report, please.

12 MR. CONSTANTINO: The applicants are
13 asking the State Board to approve the addition of
14 4 stations to an existing 12-station facility for
15 a total of 16 stations located in Rockford.

16 The cost of the project is approximately
17 \$1 million. The expected completion date is
18 January 31st, 2021. The applicants address a
19 total of 18 criteria and did not meet 2.

20 Thank you, Madam Chair.

21 CHAIRWOMAN SAVAGE: Thank you.

22 Would you like to proceed with your report.

23 MS. HIKE: Thank you. We are requesting
24 to add four stations to our Forest City dialysis

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1 clinic to establish transitional care unit for
2 home dialysis training in Rockford. Though
3 intended to support home patients and their
4 self-education and readiness for home dialysis,
5 because these chairs will be located as a pod
6 within the outpatient staff-assisted incenter
7 unit, we must get a CON to add them. If they were
8 traditional home stations, they would be exempt
9 from the CON requirement and placed in a separate
10 section of the clinic or at another unregulated
11 location.

12 My company is the national leader in its
13 commitment to home dialysis training and support
14 and clinical quality and innovation. With this
15 pod of chairs DaVita is piloting a home training
16 transitional care unit in Rockford. The home
17 dialysis transitional care unit allows select
18 clinics to have a care pod dedicated to patients
19 who have opted for the home modality or are
20 considering this modality.

21 Through this program patients will receive
22 intensive high-touch-centered introduction to
23 dialysis which typically lasts three to four weeks.
24 It is intended to reduce hospitalizations during

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1 the first 90 days of treatment and to enhance
2 modality education to promote home dialysis.
3 Additionally, 30 to 50 percent of transitional
4 care patients will ultimately choose home
5 dialysis.

6 As noted in our previous presentation,
7 many patients with kidney failure crash onto
8 dialysis and initiate dialysis in an unplanned
9 fashion. This program will support crashers by
10 educating patients on modality options, including
11 clinical and quality of life outcomes for each
12 modality, adverse effects of mistreatment, diet,
13 access, and transplant so patients are more
14 informed in selecting a modality. The transitional
15 care unit will also support patients with severe
16 uremic symptoms who could benefit from more
17 intensive initial treatment support.

18 As for the findings in the Board report,
19 projected utilization and assurance, while Forest
20 City is currently operating below target, we cannot
21 currently implement a home dialysis transitional
22 care unit in Rockford without affecting the
23 existing dialysis patients. While Forest City
24 currently operates three shifts on Monday,

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1 Wednesday, and Friday, those stations operate at
2 72 percent on those days. To ensure station
3 availability for both conventional and
4 transitional care patients we need the four
5 requested stations.

6 As discussed in our previous presentation,
7 Rockford is an economically disadvantaged
8 community with poverty rates 50 percent higher
9 than the statewide rates. Accordingly, so many of
10 our patients rely on spouses, other family
11 members, friends, and caregivers to transport them
12 to and from their dialysis, and they must schedule
13 their dialysis when transportation is available,
14 which limits scheduling options. Changing the
15 patient's shift could adversely affect his or her
16 ability to arrange transportation for his or her
17 appointment.

18 Missing dialysis treatments increases the
19 risk of cardiac complications, stroke, fluid
20 overload, and results in hospitalization.
21 Accordingly, the additional stations are needed to
22 ensure both existing patients and transitional
23 care patients have continued access to dialysis.

24 Thank you for your time and attention. I

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1 respectfully request the Board approve our project
2 to add four transitional stations to Forest City.
3 I am happy to answer any questions.

4 CHAIRWOMAN SAVAGE: Do any of our staff
5 members or Board members have questions?

6 MEMBER MARTELL: Yes. Did our staff
7 discuss the validation for transitional stations?

8 MR. CONSTANTINO: I didn't see it in the
9 application. This is the first I'm hearing of
10 this, that this is transitional care stations and
11 there's going to be a pod. I just asked George to
12 search the application, and I can't find it in
13 there. I don't know where it's at. Maybe they
14 can point it out to me.

15 CHAIRWOMAN SAVAGE: We can give her a
16 moment to look for that.

17 MS. FRIEDMAN: In the meantime, if I could
18 just -- I just had one other comment about
19 transition to home dialysis. I've probably been
20 around CKD care for 15 or 20 years, and I never
21 understood why more people didn't exercise that
22 modality, select home whether it's peritoneal or
23 in-home dialysis is quite a bit more recent.

24 Some of the issues that you see with

1 peritoneal dialysis is that once you have sort of
2 worn your peritoneum out or had too many
3 infections, you're going to end up in center
4 anyway. But with better education about infection
5 control and just general support -- you know, when
6 you crash on dialysis, you may have had very
7 little engagement with your own healthcare over
8 the course of your life, and suddenly you're being
9 asked to potentially care for yourself at home.
10 So I think that it's very daunting for many
11 patients regardless of their socioeconomic
12 situation.

13 So I'm excited for DaVita to have this new
14 program and hope to see it succeed.

15 MS. ANDERSON: And I just wanted to add we
16 all know of President Trump's executive order to
17 have every 1 of 4 patients on home dialysis.

18 CHAIRWOMAN SAVAGE: Will you talk louder.

19 MS. ANDERSON: I'm sorry. We all know
20 that President Trump has an executive order for
21 home dialysis, every 1 in 4 patients we would like
22 to see at home, and this transitional care
23 facility would support that executive order.

24 MS. FRIEDMAN: And, Mike, I can't read

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1 this, but I'm told page 114. It's the Purpose of
2 the Project section.

3 MR. CONSTANTINO: A transitional care
4 program -- what it says is a transitional care
5 program in certain facilities. I took that to
6 mean -- I didn't take this to mean this facility.

7 I had asked these folks what they were
8 doing at this clinic, and I didn't get the word
9 transitional care. They haven't met the 80 percent
10 target, so my first question would have been, and
11 I did ask them, what are you doing here at this
12 clinic wanting to add 4 stations to a 12-station
13 facility that is not at target occupancy which you
14 told the Board you would be at.

15 MS. FRIEDMAN: If I could just interject
16 for a moment, back in December we had requested a
17 technical assistance meeting with staff, and we
18 were unable to schedule it at that time, but we
19 wanted to talk about not really particularly for
20 this project but in general about how to fit the
21 transitional care unit program into your criteria
22 because it's going to look quite different.

23 When they're in a transitional care unit,
24 you have a different type of dialysis machine.

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1 It's the type of dialysis machine that will be
2 used at home. I don't remember what those
3 machines are called -- Next Stage, thank you.

4 So it's unclear when you have a patient
5 who has elected to try this transitional care unit
6 whether or not they will ultimately stay in center
7 because whether it's a medical issue or something
8 else and whether they'll -- and how long it will
9 endure. And once that patient does either
10 transition to a regular machine in the unit or
11 goes home, then it's not certain how quickly the
12 next patient will come on, and it's also not a
13 three-times-a-week modality; it's five times a week.

14 So I think it does warrant further
15 discussion as to whether or not there should be
16 different criteria if you're putting a transitional
17 care unit into your facility, but at this time they
18 do want to dedicate these 4 stations to that here.

19 MEMBER MARTELL: I guess then in follow-up,
20 in the application an alternative for conversion
21 of the existing stations not used is considered.

22 MS. FRIEDMAN: Well, one of the things to
23 point out is that this location does have the
24 capacity to add these stations.

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1 Do you want to talk a little bit about how
2 the existing stations are utilized?

3 MS. HIKE: When we originally built Forest
4 City, it was a 12-station facility, and we plumbed
5 it for 16 stations. So those additional
6 four stations are available for us to use in the
7 event that we are able to do the transitional
8 stations. So we're not currently utilizing those
9 stations right now.

10 MS. FRIEDMAN: But the question is if you
11 reduced your regular program to eight stations and
12 used four of those for a transitional care unit,
13 how would that affect the patients that are
14 currently receiving services there?

15 MS. HIKE: Their schedule would have to
16 change. We're currently at 72 percent capacity on
17 Monday, Wednesday, and Friday only. So those
18 patients' schedules would have to change to
19 Thursday, Saturday. In this particular area
20 transportation is very difficult on Saturdays for
21 patients to get to treatment, and so it would be
22 an adjustment in their schedule, and they could
23 run the risk of not being able to come on a
24 Saturday.

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1 (An off-the-record discussion was held.)

2 MS. AVERY: Okay. In my discussion with
3 Board staff and Mike as the reviewer, it does not
4 change the substance of the application, but it
5 changes the purpose of the chairs at the ESRD. I
6 asked the question, would it change the licensure
7 for IDPH, and it would not. It doesn't come into
8 any different categories of services.

9 MR. CONSTANTINO: They're not licensed
10 by IDPH.

11 MS. AVERY: Well, the whole survey thing,
12 it doesn't fit into a different category; it still
13 fits into the generic -- I used the term
14 "license"; that was incorrect.

15 So staff's recommendation is we ask the
16 applicants for deferral and take it up in April
17 because he feels he needs more information to know
18 what's going on with the actual facility and the
19 4 stations, 4 transitional stations.

20 So the Board needs to make a decision on
21 that based on what the reviewer is asking.

22 MEMBER MARTELL: I motion that we defer
23 this project.

24 MEMBER MURRAY: Second.

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1 CHAIRWOMAN SAVAGE: So, George, if you
2 could do the roll call, please.

3 MR. ROATE: Yes, ma'am. Can we go ahead
4 and redact the first motion then; is that correct?
5 First motion was made by Senator Demuzio; seconded
6 by Mr. Slater.

7 MEMBER DEMUZIO: Yes, I'm going to withdraw
8 my motion.

9 MR. ROATE: Thank you. That motion was
10 withdrawn.

11 Second motion was made by Dr. Martell;
12 seconded by Dr. Murray.

13 Senator Demuzio.

14 MEMBER DEMUZIO: Yes, to defer.

15 MR. ROATE: Dr. Martell.

16 MEMBER MARTELL: Yes, with additional
17 information requested.

18 MR. ROATE: Thank you.

19 Dr. Murray.

20 MEMBER MURRAY: Yes, to defer.

21 MR. ROATE: Thank you.

22 Mr. Slater.

23 MEMBER SLATER: Yes.

24 MR. ROATE: Thank you.

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Chairwoman Savage.

CHAIRWOMAN SAVAGE: Yes, to defer.

MR. ROATE: Thank you.

That's 5 votes in the affirmative.

CHAIRWOMAN SAVAGE: And please do follow
up with our staff so we can figure all this out.

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1 CHAIRWOMAN SAVAGE: So next on the agenda
2 then is H-07, Project 19-056, Javon Bea Hospital,
3 Rockton Avenue Campus, Rockford. May I have a
4 motion to approve an establishment of a 12-station
5 ESRD facility for Project 19-056, Javon Bea --

6 MR. ROATE: You said ESRD. It's a
7 long-term care unit.

8 MEMBER MURRAY: It's long-term care.

9 CHAIRWOMAN SAVAGE: My mistake -- I'm so
10 sorry -- to approve an establishment of a
11 long-term care facility for the Javon Bea Hospital,
12 Rockton Avenue Campus, Rockford.

13 MEMBER SLATER: Yes.

14 CHAIRWOMAN SAVAGE: A second?

15 MEMBER MARTELL: Second.

16 CHAIRWOMAN SAVAGE: All right. So please
17 identify yourselves, spell your names for the
18 court reporter, and be sworn in.

19 MR. BEA: My name is Javon Bea, J-a-v-o-n
20 B-e-a, president and CEO of Mercyhealth. To my
21 right is Mr. Jack Axel, who is our CON consultant.

22 MR. AXEL: A-x-e-l.

23 MR. BEA: To my left is Dr. John Dorsey,
24 our chief medical officer for Mercyhealth.

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1 DR. DORSEY: J-o-h-n D-o-r-s-e-y.

2 (Witnesses sworn.)

3 MR. BEA: I'd like to also introduce Kara
4 Sankey, who is our senior director of utilization
5 management and our social services. And also, we
6 have Kathy Kusp, who is the CEO of our subacute
7 unit at our Janesville Hospital in Janesville,
8 Wisconsin, and we have Juan Morado, who is our
9 consulting attorney, and Paul Van Den Heuvel, who
10 is our general counsel.

11 CHAIRWOMAN SAVAGE: Mr. Constantino, if
12 you could please give the State Board staff report.

13 MR. CONSTANTINO: Thank you, Madam Chair.

14 The applicants are asking the State Board
15 to approve the establishment of a 17-bed skilled
16 care unit at a cost of approximately \$5.3 million.
17 The expected completion date is August 31st, 2020.
18 No public hearing was requested, and no letters of
19 opposition were received. Letters of support have
20 been received by the State Board and are included
21 at the end of this report.

22 The applicants have addressed a total of
23 23 criteria and have not met 4 of those criteria.

24 I would like to point out the Board does

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1 not have a subacute category of service, that this
2 is being reviewed under the long-term care rules.

3 Thank you, Madam Chair.

4 CHAIRWOMAN SAVAGE: Thank you.

5 Please proceed with your statement.

6 MR. BEA: Thank you. As I said, my name
7 is Javon Bea, and I'm the president and CEO. I'll
8 be using the term subacute often, but it is being
9 requested as skilled care beds.

10 So at Javon Bea Hospital in Rockford, we
11 operate acute care hospital beds on two Rockford
12 campuses, and we're requesting the addition of a
13 17-bed subacute care unit in our Rockton Avenue
14 hospital.

15 The fact is, Board members, we are stuck
16 in a catch-22 where we are being forced to hold
17 patients in our emergency room for long periods of
18 time because we don't have any acute care hospital
19 beds available for them, and that's because
20 patients that are ready to be discharged from our
21 subacute -- our acute care beds have nowhere else
22 to go.

23 At the same time that we're required to
24 hold these patients in the emergency room, the

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1 volume of these patients has been accelerating
2 greatly over the last a couple of years. Last
3 year in 2019 we held 10,000, 10,021 patients in
4 our emergency room for a total of 43,204 hours for
5 an average of more than 4 hours. 876 of these
6 patients were held for an average of 12 or more
7 hours. This is in addition and on top of the
8 number of hours they've spent going to through the
9 emergency room process, and an admitting order has
10 been written and there's no bed available for them.

11 So we have a solution to this problem that
12 we've been working on, and we're seeking your
13 approval so that we can provide the right level of
14 care in the right setting for our patients, and
15 the plan is relatively simple. We're proposing to
16 open a 17-bed subacute unit for patients who no
17 longer need to be in a medical/surgical acute care
18 bed and yet for those patients at skilled nursing
19 homes feel that they're still not able to provide
20 some level of care that the patient may still
21 need, and I'll be giving you examples of that a
22 little later.

23 In addition, it takes almost 4 to 7 days
24 to transfer a patient from our acute care bed to a

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1 skilled nursing home, unnecessarily increasing the
2 cost of care to the hospital and the government
3 payors. In other words, this is not in competition
4 with nursing homes, and, in fact, none of the area
5 nursing homes object to this project.

6 We've met with several of the area nursing
7 homes, and they understand the type of patients
8 we're planning to move from our acute care beds to
9 a subacute bed until the nursing homes are ready
10 to accept them. This approach has not been used
11 often in Illinois because the fact is there's few
12 hospitals in Illinois that find themselves
13 frequently at or near full capacity like we do at
14 our Mercyhealth hospitals in Rockford, but this
15 approach has been used in Wisconsin for years.

16 At our Mercyhealth Hospital and Trauma Center
17 in Janesville, Wisconsin, we have successfully
18 operated for 20 years a five-star subacute unit
19 called Mercyhealth Transitional Care Center on the
20 5th floor of the hospital.

21 I'd be happy to provide you examples of
22 patients that we treat in our subacute unit at our
23 hospital in Janesville, for it is these same types
24 of patients that we'll be treating in our subacute

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1 unit at our Rockton Avenue hospital in Rockford.
2 The Mercyhealth subacute unit in
3 Janesville cares for many patients who, again, no
4 longer need to be in an acute care bed but skilled
5 nursing homes routinely denied until the nursing
6 home is prepared to accept them. These patients
7 include patients requiring medication management
8 by specialized physicians on a daily basis,
9 patients involved in motor vehicle accidents who
10 may need monitoring but not in an acute care bed,
11 patients needing frequent diagnostic modalities
12 such as imaging, patients who need to be followed
13 up by certain medical specialists, patients not
14 yet able to tolerate enough daily therapy, thus
15 delaying admission to a rehabilitation unit or
16 hospital, patients with a variety of social issues
17 such as sex offenders or patients with criminal
18 backgrounds, thus delaying acceptance to a nursing
19 home, patients needing high-cost room care, IV
20 antibiotics which require daily monitoring by the
21 physician, and patients whose payor source has yet
22 to be established by a nursing home.
23 Based on our experience at our Janesville
24 subacute unit and delays that we've experienced

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1 with transfers out of Javon Bea Hospitals each
2 year over the last two years, we estimate that
3 we'll be providing between 5,800 and 5,900 patient
4 days a year in our Rockford subacute unit. This
5 supports 17 beds at a 95 percent occupancy.

6 Patients residing in a skilled nursing home
7 prior to their admission to our Rockford hospital
8 would not be admitted to our subacute care unit
9 unless the nursing home tells us they're not
10 prepared to receive the patient back. Just as we
11 would not be soliciting and accepting patients
12 from the community at large in our subacute unit,
13 only Mercyhealth patients from our medical surgical
14 units would be admitted to our subacute unit.

15 The proposed subacute care unit before you
16 today is a solution to stop the catch-22 that we
17 are in with our clogged emergency rooms with no
18 acute care beds available for those patients
19 because they are ready to be discharged from our
20 acute care bed, but a nursing home is not prepared
21 yet to accept them. Thus, we will be providing a
22 subacute level of care in licensed Illinois
23 skilled care beds that are reimbursed by Medicare,
24 but we will be providing care to Medicaid patients

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1 under our charity care status until we can get
2 these patients accepted into an established
3 licensed Illinois Medicaid nursing home.

4 I'd like to note again that none of the
5 area nursing homes oppose this project. We
6 appreciate the letters of support that we have
7 received from a variety of sources, including
8 nursing homes and four area legislators whose
9 constituents will be the beneficiaries of this
10 project.

11 So in summary, if I could just summarize,
12 this project will result in better patient outcomes,
13 reduce the number of patients being held in the
14 emergency rooms for long periods of time, free up
15 beds for patients who truly need an acute care
16 bed, result in improved patient care coordination,
17 reduce the cost of care for both the hospital and
18 the government payors, and increase patient
19 satisfaction by patients not having to wait long
20 hours in the emergency room to be admitted to a bed.

21 I strongly urge you to please support this
22 project. Thank you.

23 MR. AXEL: Thank you and my comments will
24 be brief.

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1 As Mr. Bea explained, we are proposing to
2 provide a subacute level of care in skilled
3 nursing beds simply because, and as noted in the
4 project description section of the staff report, the
5 Board has no rules specific to subacute care beds
6 nor does it have any rules for the establishment
7 of a long-term care unit in a hospital.

8 As a result, we worked with staff to set
9 parameters for a somewhat hybrid application
10 addressing 23 review criteria, some of which were
11 from the hospital application and some from the
12 nursing home application.

13 I want to personally thank staff for working
14 with us through this process. I also want to note
15 that the adding of skilled care beds to the hospital
16 is not unique at all. In fact, there are already
17 13 hospitals in the state that operate skilled care
18 units.

19 Of the 23 review criteria we were evaluated
20 against, we were found to be in compliance with
21 19, including all of the criteria addressing
22 project size, all of the criteria addressing demand
23 and number of beds and all of the financial
24 criteria. The four criteria that we could not meet,

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1 all of which are beyond our control, are a direct
2 result of two issues, that being a calculated
3 excess of skilled care beds in the area, nursing
4 home beds, if you will, and a low occupancy rate
5 at some of the area nursing homes.

6 The four criteria, as you may have noted,
7 are all from Section 1125 of your rules signifying
8 that they were developed for nursing homes. Those
9 four criteria are, one, the planning area need
10 criterion which received a negative finding because
11 of calculated excess of skilled care beds in the
12 area. Two, the service accessibility criterion
13 which received a negative finding because some of
14 the area facilities are failing to operate at
15 90 percent. Three, the unnecessary duplication
16 and maldistribution of criterion again resulting
17 in a negative finding because some of the
18 facilities are failing to operate at 90 percent
19 occupancy. And four, the impact of the project on
20 other providers' criterion once again resulting in
21 a negative finding because some of the area
22 facilities are operating below the 90 percent
23 occupancy target.

24 There are approximately 2200 skilled care

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1 beds, all in nursing homes in Winnebago County. On
2 the surface that sounds like a lot but apparently
3 it isn't. As calculated by your staff and provided
4 on page 13 of the staff report, the skilled care
5 bed to population ratio Winnebago is 1 skilled
6 care bed per 303 residents. Statewide it's 1 bed
7 per 143 residents. Therefore, the supply of
8 skilled care beds in Winnebago County is less than
9 half of that of the state as a whole.

10 It's hard to imagine that the proposed
11 17-bed subacute care unit given the 2200 beds in
12 the area will have much of an impact on the area
13 nursing homes, and I suspect that is why none of
14 them have voiced opposition either in writing or
15 in person to this project.

16 In closing, we are asking for beds, and
17 for that reason staff is required to hold the beds
18 up against a bed need calculation for one of the
19 10 existing bed categories, therein resulting in
20 the four negative findings.

21 The Board, of course, as it often does,
22 has the authority and the ability to look beyond
23 the simple arithmetic bed need calculation and
24 approve this project, and given that we are

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1 proposing a level care not available in the
2 planning area and therefore a service that will
3 not result in any duplication, we would appreciate
4 your support.

5 At this point I'll turn the microphone
6 back to Mr. Bea for closing comments.

7 MR. BEA: Just to say thank you very much,
8 and we would be happy to answer any questions that
9 you have.

10 CHAIRWOMAN SAVAGE: I'm wondering if you
11 can differentiate a little bit for our Board the
12 difference between subacute and skilled nursing
13 home care.

14 MR. BEA: This is Kara Sankey, who is the
15 head of our utilization management social
16 services. All the folks behind you were sworn in.

17 MS. SANKEY: By definition there's really
18 no difference between subacute and skilled care.
19 However, it's what the facilities that we're
20 referring to can provide.

21 So we have patients often that are
22 requiring very expensive antibiotics or patients
23 that require very complex wound care that can't be
24 managed at the facility, so that results in much

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1 longer stays at the hospital when they really
2 aren't requiring hospital level of care anymore.
3 So essentially, it's identical, just the level of
4 services that can be provided in that facility.

5 CHAIRWOMAN SAVAGE: Okay. Thank you.

6 Other questions or comments from the Board
7 or staff?

8 MR. AXEL: Madam Chair, may I just chime
9 in on that last issue? And that is why the beds
10 that we are requesting will be categorized as
11 skilled care beds.

12 MEMBER MARTELL: I want to have it stated
13 for the record, you're not planning to run a
14 skilled nursing facility, long-term care facility?

15 MR. BEA: Yeah, the last thing we want to
16 do is open up a nursing home, skilled care
17 facility. That's why we're not accepting patients
18 from the community at large. This is really a
19 transition between the patient not meeting acute
20 care bed criteria anymore but a nursing home not
21 being able to accept the patient. So it's for
22 short-term transition periods.

23 MEMBER MURRAY: So I just want to make
24 sure that I've understood you correctly. So you

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1 have acute care patients who get better and really
2 no longer need to be in an acute care bed, and you
3 want to put them in an appropriate skilled nursing
4 bed, which will help with the reimbursement issue,
5 a Federal issue primarily, I'm assuming, with
6 Medicare. But our State regulation doesn't have a
7 category for hospital-based subacute beds. Is
8 that a fair summary?

9 MR. AXEL: That is correct. There is no
10 category subacute beds, but there is a category
11 skilled care beds that is used by 13 hospitals
12 around the state that have skilled care units in
13 addition to all of the smaller hospitals that have
14 swing beds. But among the 13 hospitals are
15 significantly sized hospitals, MacNeal in the
16 Chicago area, St. Joseph in Chicago in the Lincoln
17 Park area, Harvard Hospital has skilled care beds.
18 So there are quite a few hospitals around that
19 already provide those.

20 MEMBER MURRAY: So what is the problem
21 with -- now I'm more confused about why you had
22 trouble with these criterion, these four
23 criterion. Because you could -- we do have a
24 category of skilled nursing beds.

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1 MR. AXEL: Yes, there is a category of
2 skilled nursing beds. Virtually all of those beds
3 are located in nursing homes.

4 MEMBER MURRAY: Okay. I understand.

5 MR. AXEL: So staff has to hold us up
6 against some category of beds. Well, the choice
7 is acute care beds or skilled care beds, and the
8 decision was made to compare the project to
9 skilled care beds.

10 MR. BEA: The whole idea is to, you know,
11 free up acute care beds because our emergency
12 rooms are clogged. Patients who don't meet their
13 acute care criteria, but the nursing homes aren't
14 ready to take them because they may need daily
15 monitoring by a physician, and the nursing homes
16 don't want to be transporting by ambulance which
17 they have to pay for, or a patient to go a
18 doctor's office every day for a patient who needs
19 to be monitored for medication or some other such
20 purpose. Dr. Dorsey might have a comment because
21 he runs into this quite frequently.

22 DR. DORSEY: Yes, this is something that
23 happens regularly, routinely, daily, difficulty
24 getting patients out of the hospital where they no

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1 longer need to be, and the nursing facilities just
2 can't handle the patient's clinical condition.
3 They do not meet inpatient criteria.

4 As we know, we have really the sickest of
5 the sick in the hospitals, but many of the people
6 are transitioning out of the hospital still quite
7 ill who still need routine daily care, and that's
8 the focus that we have trouble placing.

9 The other categories, as Mr. Bea listed,
10 are real, as well, where we have payor source
11 pending, or social behavioral issues, as well.
12 But it's really the medical patients, and in this
13 particular model, as soon as the facilities have
14 the willingness to accept those patients, we will
15 send them on. We don't want to be in this as a
16 business model; it's simply a transition so that
17 we can then get the patients who truly need the
18 acute beds that are in the hallways in the ED in
19 the right location for the right care.

20 CHAIRWOMAN SAVAGE: If I can ask one
21 question, in your area where your hospital is
22 located, are the nursing homes, the long-term
23 facilities, do they not have skilled units that --
24 is it the acuity of the patient and they can't

1 take them in their regular skilled nursing
2 facility.

3 MR. BEA: I think it's where they need
4 daily monitoring by specialty physicians. In the
5 hospital we have a whole host of specialty
6 physicians all the time. So if a patient is on
7 some expensive wound care IV antibiotic, it's easy
8 for that specialty to monitor, like an infectious
9 disease specialist to go up to the subacute unit
10 and monitor that patient each day on those subacute
11 wound care antibiotics.

12 If the patient is on the IV wound care and
13 arrives in the nursing home, the infectious
14 disease physician can't run to the nursing home
15 every day just like doctors can't leave their
16 office every day to run to a nursing home. So the
17 nursing home will say, "We don't want the patient
18 until they're off that level of care because we
19 don't have an infectious disease specialist, and
20 we know your infectious disease specialist isn't
21 going to come to the nursing home every day, and we
22 can't pay to transfer him every day by ambulance."

23 MR. AXEL: Those are the clinical cases.
24 And the nonclinical cases are those patients who

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1 are ready to leave the hospital, they're ready to
2 go to the nursing home, but the nursing home isn't
3 willing to take them until they have been assured
4 that Medicare will pay for them, Medicaid will pay
5 for them, Blue Shield, or whoever, and that typically
6 takes somewhere between four and seven days. So
7 that's a large group of the patients, also.

8 MS. BRYARS: I have a question. You
9 indicated that in your area when you do a referral
10 to a long-term care facility that has skilled
11 care, they're not able to provide the services.
12 Is this something that you're seeing frequently or
13 just for a particular category of client such as if
14 you have a person that has maybe an SMI diagnosis
15 or what are you -- because I note that you
16 included that.

17 MR. BEA: Enough to keep 17 beds occupied
18 at 90 percent occupancy 365 days a year.

19 MS. SANKEY: So yes, oftentimes there are
20 mental health diagnoses that are associated with
21 it. We are making the referrals. A lot of the
22 times it's a mutual discussion between the
23 facilities and the case managers to discuss when
24 and how will you be able to manage the care of

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1 this patient on an ongoing basis, and typically
2 it's related to the frequency of the dressing
3 changes or the frequency in the assessment needs.
4 They may require a sitter or one-to-one
5 supervision that can't be provided under those
6 circumstances.

7 So it's a very ongoing conversation with
8 the facilities to discuss when and how can they
9 handle those cases and transition them safely to
10 that level.

11 MS. BRYARS: And you also mentioned the
12 payor source. How does the payor source relate to
13 the category of service?

14 MS. SANKEY: So under some of the Medicaid
15 plans, sometimes patients aren't able to get all
16 of the therapies that they need inside a skilled
17 nursing facility. So some of those cases are going
18 to be better suited at a facility where we can
19 continue to give them a skilled need. Also, some
20 of the facilities, if there's a borderline if
21 they're going to meet Medicaid eligibility or not,
22 those facilities want to assure that there is
23 going to be some payment source in place before
24 they're accepting them and having to do that. So

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1 that is the group that we look at in that range.

2 CHAIRWOMAN SAVAGE: Other questions?

3 (No response.)

4 CHAIRWOMAN SAVAGE: Seeing none,
5 Mr. Roate, if you could do the roll call.

6 MR. ROATE: Thank you, Madame Chair.

7 Motion made by Mr. Slater; seconded by
8 Dr. Martell.

9 Senator Demuzio.

10 MEMBER DEMUZIO: Yes, based on the
11 testimony I've heard and the State report.

12 MR. ROATE: Thank you.

13 Dr. Martell.

14 MEMBER MARTELL: Yes, based on State
15 report, testimony here today, and discussion.

16 MR. ROATE: Thank you.

17 Dr. Murray.

18 MEMBER MURRAY: Yes, based on the
19 application and discussion today.

20 MR. ROATE: Thank you.

21 Mr. Slater.

22 MEMBER SLATER: Yes, based on the staff
23 report and the testimony.

24 MR. ROATE: Thank you.

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1 Chairwoman Savage.

2 CHAIRWOMAN SAVAGE: Yes, based on the
3 staff report and the discussion today.

4 MR. ROATE: Thank you.

5 That's 5 votes in the affirmative.

6 CHAIRWOMAN SAVAGE: Motion is approved.

7 And we are going to take a very short break.

8 (Recess taken, 1:59 p.m. to 2:08 p.m.)

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Transcript of Open Session - Meeting
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1 CHAIRWOMAN SAVAGE: Welcome back again.
2 Next on our agenda we have I'm H-08,
3 Project 19-057, OSF St. Francis Medical Center in
4 Peoria. May I have a motion to approve an
5 establishment of comprehensive cancer center for
6 Project 19-057, OSF St. Francis Medical Center,
7 Peoria.

8 MEMBER MURRAY: So moved.

9 CHAIRWOMAN SAVAGE: A second.

10 MEMBER DEMUZIO: Second.

11 CHAIRWOMAN SAVAGE: If you can please
12 identify yourselves, spell your names, and be
13 sworn in.

14 MR. ANDERSON: Bob Anderson,
15 A-n-d-e-r-s-o-n.

16 DR. MCGEE: Dr. James McGee, M-c-G-e-e.

17 MS. FRIEDMAN: And I'm Kara Friedman with
18 Polsinelli.

19 (Witnesses sworn.)

20 CHAIRWOMAN SAVAGE: Mr. Constantino, the
21 State Board staff report.

22 MR. CONSTANTINO: Thank you, Madam Chair.

23 The applicant is asking the State Board to
24 approve the establishment of a comprehensive

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1 cancer on the campus of OSF St. Francis Medical
2 Center in Peoria, Illinois. The project will
3 include a 10-story parking garage to support the
4 overall hospital campus.

5 The cost of the project is \$237 million, and
6 the expected completion date is June 30th, 2024.
7 No public hearing was requested, and no letters of
8 opposition were received. Letters of support were
9 received and included at the end of your report.

10 I would like to point out on page 17 of
11 the report I had stated that these folks had
12 exceeded the State standard of A & E fees of
13 \$1,767,000 which are 8.2 percent of the new
14 construction and contingency costs. When I stated
15 that, I viewed that as an outpatient facility and
16 not as a hospital standard. We have two different
17 standards. If I look at it through the hospital
18 standard, they have met this requirement. I
19 apologize for that.

20 Thank you, Madam Chair.

21 CHAIRWOMAN SAVAGE: Thank you, Mike.

22 So if you would like to please proceed
23 with your statement to the Board.

24 MR. ANDERSON: Good afternoon. My name is

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1 Bob Anderson. I'm the president of OSF St. Francis
2 Medical Center. As stated, with me is Dr. Jim McGee,
3 director of our radiation/oncology program and our
4 outside counsel, Kara Friedman from Polsinelli.

5 I'd like to thank the many organizations
6 and individuals who provided support letters for
7 our project, as well as Mr. Mike Constantino for
8 his thorough review of our application to
9 establish a comprehensive cancer center.

10 The staff report for this project is fully
11 positive, so with that we do not have a formal
12 presentation but would be happy to answer any
13 questions you may have.

14 CHAIRWOMAN SAVAGE: Questions from the
15 Board members or staff?

16 Go ahead.

17 MEMBER DEMUZIO: I just have one quick
18 question. I know you have a proton beam therapy.
19 Do you already have that, or is that going to be
20 something new?

21 MR. ANDERSON: We do not. There is only
22 one proton beam therapy unit in Illinois at
23 Northwestern. So this would be the second and the
24 only one downstate.

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1 MEMBER DEMUZIO: But presently you do not
2 have one.

3 MR. ANDERSON: No. There are only 37 in
4 the United States, so it's not something that's
5 very common.

6 MEMBER DEMUZIO: Okay.

7 CHAIRWOMAN SAVAGE: And that would be part
8 of the cost issue.

9 MR. ANDERSON: That's correct.

10 CHAIRWOMAN SAVAGE: Other questions or
11 comments by the Board or staff members?

12 (No response.)

13 CHAIRWOMAN SAVAGE: Seeing none, Mr. Roate,
14 if you could do the roll call.

15 MR. ROATE: Thank you, Madam Chair.

16 Motion made by Dr. Martell; seconded by
17 Senator Demuzio.

18 Senator Demuzio.

19 MEMBER DEMUZIO: Yes, based upon the
20 report and your comments.

21 MR. ROATE: Thank you.

22 Dr. Martell.

23 MEMBER MARTELL: Yes, based on staff report.

24 MR. ROATE: Thank you.

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1 Dr. Murray.

2 MEMBER MURRAY: Yes, based on the
3 application and staff report.

4 MR. ROATE: Thank you.

5 Mr. Slater.

6 MEMBER SLATER: Yes, based on staff report.

7 MR. ROATE: Thank you.

8 Chairwoman Savage.

9 CHAIRWOMAN SAVAGE: Yes, based on the
10 staff report.

11 MR. ROATE: Thank you.

12 That's 5 votes in the affirmative.

13 CHAIRWOMAN SAVAGE: Your motion is approved.

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1 CHAIRWOMAN SAVAGE: Next on the agenda is
2 Project H-09 -- I'm sorry -- Project 20-006
3 Fresenius Kidney Care of Galesburg. May I have a
4 motion to approve an addition of 5 ESRD stations
5 for Project 20-006, Fresenius Kidney Care
6 Galesburg in Galesburg.

7 MEMBER SLATER: I move to approve.

8 CHAIRWOMAN SAVAGE: Second.

9 MEMBER MARTELL: Second.

10 CHAIRWOMAN SAVAGE: Please identify
11 yourself.

12 MS. WRIGHT: I was sworn in previously.
13 Again, my name is Lori Wright, L-o-r-i W-r-i-g-h-t.
14 I'm a senior CON specialist, and I want to thank
15 all the Board members for their time here, and I
16 want to thank the Board staff for their positive
17 review of this application.

18 It does meet all your criteria, so I'd be
19 happy to answer all your questions.

20 CHAIRWOMAN SAVAGE: Mr. Constantino, the
21 State Board staff report.

22 MR. CONSTANTINO: Thank you, Madam Chair.

23 The applicant is asking the State Board to
24 approve the addition of 5 ESRD stations to an

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1 existing 16-station facility in Galesburg, Illinois,
2 at a cost of \$117,000. No public hearing was
3 requested, and no letters of support or opposition
4 were received. The applicant has met all the
5 requirements of the State Board.

6 Thank you, Madam Chair.

7 CHAIRWOMAN SAVAGE: Thank you.

8 Any other comments?

9 MS. WRIGHT: I guess I jumped a little bit
10 ahead. I'd be happy to answer any questions.

11 CHAIRWOMAN SAVAGE: Questions by staff or
12 Board?

13 (No response.)

14 CHAIRWOMAN SAVAGE: Not seeing any, a roll
15 call vote, please.

16 MR. ROATE: Thank you, Madam Chair.

17 Motion made by Mr. Slater; seconded by
18 Dr. Martell.

19 Senator Demuzio.

20 MEMBER DEMUZIO: Yes, based upon the staff
21 report and testimony.

22 MR. ROATE: Thank you.

23 Dr. Martell.

24 MEMBER MARTELL: Yes, based on staff report.

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1 MR. ROATE: Thank you.

2 Dr. Murray.

3 MEMBER MURRAY: Yes, based on the staff
4 report.

5 MR. ROATE: Thank you.

6 Mr. Slater.

7 MEMBER SLATER: Based on staff report, yes.

8 MR. ROATE: Thank you.

9 Chairwoman Savage.

10 CHAIRWOMAN SAVAGE: Yes, based on staff
11 report.

12 MR. ROATE: Thank you.

13 That's 5 votes in the affirmative.

14 CHAIRWOMAN SAVAGE: Your motion is approved.

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1 CHAIRWOMAN SAVAGE: Moving on to our next
2 agenda item, which is H-10, Project No. 20-003,
3 Burr Ridge Birth Center in Burr Ridge. May I have
4 a motion to approve an establishment of a birth
5 center for Project 20-003, Burr Ridge Birth Center,
6 Burr Ridge.

7 MEMBER SLATER: I move to approve.

8 CHAIRWOMAN SAVAGE: A second.

9 MEMBER DEMUZIO: Second.

10 CHAIRWOMAN SAVAGE: If you could please
11 identify yourselves, spell your names, and be
12 sworn in.

13 MS. LORENZ: Good afternoon, I am
14 Kathleen, K-a-t-h-l-e-e-n; Lorenz, L-o-r-e-n-z,
15 and I am the CON project consultant.

16 MS. WIEGAND: Laura Wiegand, W-i-e-g-a-n-d,
17 the administrator at Burr Ridge Birth Center.

18 DR. OGUNLEYE: Hello, my name is Dele
19 Ogunleye, D-e-l-e O-g-u-n-l-e-y-e, and I'll be the
20 medical director of Burr Ridge Birth Center.

21 MS. STETINA: Hello, I'm Sarah Stetina,
22 S-t-e-t-i-n-a. I am a certified nurse midwife,
23 and I'll be the director of the program.

24 (Witnesses sworn.)

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1 CHAIRWOMAN SAVAGE: Mr. Constantino, the
2 staff report.

3 MR. CONSTANTINO: Thank you, Madam Chair.

4 The applicants are asking the State Board to
5 approve a three-bed birthing center in Burr Ridge,
6 Illinois. The anticipated cost of the project is
7 approximately \$1.9 million, and the anticipated
8 completion date is December 31, 2021.

9 This project is being submitted under the
10 Alternative Health Care Delivery Act. This act is
11 intended to development of innovations through the
12 development of demonstration projects to license
13 and study alternative healthcare delivery systems.
14 These demonstration projects are regulated by the
15 Department of Public Health. The three
16 alternative healthcare models that require your
17 approval are birth centers, the current application,
18 community-based residential rehab centers, and
19 freestanding emergency centers.

20 The applicants before you today have met
21 all the requirements of your Board's rules. Thank
22 you, Madam Chair.

23 CHAIRWOMAN SAVAGE: Thank you.

24 If you'd like to please present your case.

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1 DR. OGUNLEYE: Good afternoon and thank
2 you for your attention. I know it's been a long
3 day for you guys.

4 Madam Chair, Board members, and staff, on
5 behalf of everyone sitting at this table today I
6 would like to thank you for allowing us to present
7 and talk to you about the birth center project in
8 Burr Ridge. As I said earlier, my name is
9 Dr. Dele Ogunleye. I'm a board-certified ob/gyn,
10 and I have been licensed and been practicing in
11 the state of Illinois for over 15 years.

12 It was just five years ago that we came
13 before the same Board to seek approval for our
14 first birth center, the Birth Center of
15 Bloomington Normal. Included in your report we
16 have a summary of our experience so far.

17 In 2016 we were licensed and accredited,
18 and by the end of 2017 we had our 100th delivery.
19 Last month we crossed over the 300 threshold of
20 deliveries at the Birth Center of Bloomington
21 Normal. We continue to experience a great growth
22 rate. Last year we had 21 percent growth rate.
23 This year we expect similar or better growth.

24 The Bloomington Normal Birth Center has a

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1 5 percent C-section rate. That compares to a
2 national average of 32 percent. We've had
3 23 transfers to the hospital, 20 of them
4 intrapartum, two postpartum, and one neonatal.

5 The patients that come to the birth center
6 of Bloomington Normal, over half of them come from
7 outside McLean County. Some drive from as far as
8 St. Louis, some come from Rockford, but quite a
9 few of them come from Chicago metro. We know that
10 the demand for safe out-of-hospital alternatives
11 for low-risk pregnancy is evident in the
12 Bloomington Normal Birth Center.

13 The central piece of birth center care is
14 the midwifery model of care, and it is a safe and
15 proven, centuries old alternative to hospital care
16 for low-risk patients. Laboring and giving birth
17 under the guidance of a midwife in a birth center
18 does not mean sacrificing appropriate care or safety.
19 Low intervention does not mean no intervention or
20 no care. Our birth centers are equipped with the
21 necessary medications, supplies, equipment, and
22 safety protocols.

23 The American College of Obstetrics and
24 Gynecology and the American Academy of

1 Pediatricians, together with Society of Fetal
2 Maternal-Fetal Specialists all support freestanding
3 birth centers as a first line of care for low-risk
4 pregnant patients. Birth centers reduce overall
5 cost of care by over 30 percent, they reduce
6 C-section rates, and they meet the demand for
7 out-of-hospital births, which is the fastest
8 growing segment of people delivering in this
9 country.

10 If you would allow me, I would like to
11 briefly discuss two studies that were recently
12 published.

13 The first study was the National Birth
14 Center study that was published in 2013. This
15 study looked at 79 birth centers from 33 states
16 and studied 15,000 low-risk pregnancies, and they
17 found in that study that there were 94 percent
18 vaginal birth rate and 6 percent C-section rate.
19 This compared at that time to a C-section rate
20 nationally of 28 percent. The outcomes from the
21 point of view of the baby were similar.

22 The other study which was authored by the
23 Center for Medicaid and Medicare Services was
24 called a Strong Start Initiative, and they looked

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1 at 10,000 patients in 47 birth centers, and they
2 found that those who received prenatal care in the
3 birth center had better outcomes and lower costs
4 than other Medicaid beneficiaries. Rates of
5 preteen births, low birth weight, and CEsarian
6 section were lower amongst patients who were in
7 the birth center. The cost was also much lower,
8 about \$2,000 per each mother and child compared to
9 other Medicaid beneficiaries.

10 I believe that Illinois put itself on the
11 right path nearly a decade ago when it voted for
12 and passed the Alternative Health Care Delivery
13 Act. This act not only saves costs, but it has
14 also put the state on a path towards meeting the
15 demand for safety alternatives to traditional
16 obstetric care in the hospital. If we consider
17 Illinois to be close to the center the Midwest,
18 there are other states around us that have birth
19 centers -- many of them actually have double digit
20 birth centers -- from Wisconsin, to Indiana, to
21 Minnesota.

22 Recently we got a call from Beloit
23 Healthcare because they're wanting to put a birth
24 center just across the border in Wisconsin, and

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1 they wanted to find out how we did it. There are
2 over 400 birth centers nationwide.

3 So how did we pick Burr Ridge for a birth
4 center? Well, like I said, there are quite a few
5 patients that drive from the Chicago area to
6 Bloomington Normal, and we're always focused on
7 safety. If anyone has looked at the weather
8 forecast lately, there may be 8 inches of snow
9 tomorrow, and that's one of those things we always
10 think about when patients are driving from
11 two hours away.

12 All patients at the birth center have to
13 come for their prenatal visits in the birth center
14 together with delivery. So we decided to look at
15 places closer to the homes of where many of these
16 patients drive from. The next thing we had to
17 figure out is which hospitals would collaborate
18 with us, and in our search for different hospitals,
19 actually, we came to Amita Hinsdale. They were
20 very willing to cooperate with us and collaborate
21 with us, but also, they had standards that met the
22 needs that we always wanted to have in the birth
23 center. Hospitals that had good outcomes that
24 work with midwives and were happy to answer to

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1 protocols with us that would make the birth
2 center safe. The next thing we had to pick out
3 was an emergency medical service that would work
4 with the birth center to help make easy and
5 seamless transfer of patients to the hospital.

6 Once we were able to get all those pieces in
7 place, then we realized that DuPage County would
8 be the county where we would have to get an
9 application for a CON, and we knew DuPage County
10 did not have any other birth centers and it met
11 with the guidelines of the Alternative Health Care
12 Delivery Act which said not more than two birth
13 centers could be in any health planning area.

14 We found a property on County Line in Burr
15 Ridge. First of all, we had to find a property that
16 met the requirements of a birth center, and
17 sometimes that's a little bit tricky, but we found
18 one in Burr Ridge. And we had to apply for a
19 special use permit because there was nothing so
20 zoned for a birth center in Burr Ridge. And the
21 Village of Burr Ridge, the board had to unanimously
22 vote for us to be able to get a special permit for
23 that location.

24 In proposing the DuPage County location, we

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1 are compliant with the location requirement of
2 four birth centers allowed in a six-county region
3 of Cook, DuPage, Kane, Lake, McHenry, and Will
4 Counties. This administrative rule is reflective
5 of the potential market demand, which last year
6 about 95,000 birth certificates were issued in
7 that six-county area.

8 And if we look at 83 percent of all births
9 being low-risk, and we know that 6 percent of
10 patients would so choose a birth center, if all
11 the four birth centers that are allowed under the
12 Alternative Care Act are taken, that would be
13 5,000 births for all the four birth centers.

14 The proposed birth center will be the
15 second in the multicounty area with Berwyn's PCC
16 Wellness to the north just about 18 miles. The
17 Berwyn center has two beds, and the proposed
18 Burr Ridge Birth Center will have three beds.
19 Together both birth centers will work in a
20 complementary fashion to meet the potential market
21 demand.

22 To this end I spoke to the manager of
23 Berwyn Wellness Center, and I talked to her about
24 what our business model is and what we're looking

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1 to actually accomplish. There are some differences
2 between the birth center in Berwyn and our proposed
3 birth center. The birth center in Berwyn is an
4 FHQC, and by nature they are 100 percent Medicaid
5 patients. By statute this is an independent birth
6 center. As you may know, the Alternative Health
7 Care Act calls for four birth centers, one to be a
8 Federally qualified health center, one to be
9 hospital owned, and two to be independent.

10 If the market radius is about 15 to 18 miles,
11 and the American Association of Birth Center
12 Guidelines, ABCG says that roughly the market area
13 is 25 to 30 miles. That's just an average and
14 that's an average from about 400 birth centers
15 nationwide. So it stands to reason that a birth
16 center that is in a less populated area would have
17 a wider market radius compared to one that is in a
18 densely populated area like Chicago. So our birth
19 center in Bloomington people drive quite a long
20 way, but in Chicago 10 miles covers a lot of
21 people. So I think that would be more in keeping
22 with what the Alternative Health Care Act intended.

23 The last point I would like to address is
24 in the report that was submitted to the Board.

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1 There was a comment about excess beds in the
2 Area 5 planning area, and it said there will be
3 90 excess obstetric beds. We assert that the
4 Alternative Health Care Act is separate from the
5 traditional obstetric beds.

6 One of the things that I do know is there
7 may be reasons why there are excess beds. One of
8 the studies that have been -- we've been seeing
9 lately is a study from the Center for Disease
10 Control that has been tracking those that deliver
11 outside hospitals. Lately they have seen that
12 there is a sharp uptick in people that deliver
13 outside hospitals, and that has continued to be
14 quite a doubling factor over the last few years.

15 There was another study that was released
16 by the Journal of Perinatal Medicine that looked
17 at trends of out-of-hospital births in the United
18 States from 2009 to 2014, and it noted that those
19 that delivered outside hospitals increased by
20 80 percent in that time, and those that delivered
21 in a freestanding birth center increased by
22 79 percent in that time.

23 And I would like to end this talk, if I
24 may, Madam Chair, by sharing with you a learning

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1 moment that I had a few years ago, maybe about
2 three years before we started thinking about our
3 first birth center. I'm an ob/gyn, so I had a
4 patient who was 41 who came to see me in the
5 office; she was about 5 foot 2, and she was coming
6 in for her 7th baby. And she was 10 weeks, and I
7 was looking through her history, and her first
8 child was delivered at home, second child was
9 delivered at home, long story short all her
10 six previous children were delivered at home. And
11 as I raised my head up to ask a question, she
12 said, "I know what you're thinking. You're
13 wondering why did I come in this time," and I
14 said, "Yes, I was thinking that." And she said,
15 "Well, my husband is sitting in the waiting area,
16 and he made me promise that if we ever had another
17 baby we would be delivering it in the hospital."
18 And I said, "Why is that?" She said, "I pushed for
19 four hours, eventually had a 9-pound baby." They
20 lived in the country, there was 6 inches of snow
21 outside, and she knew that there was no way an
22 ambulance would be able to make it to them if she
23 had to go to the hospital.

24 I believe the Alternative Health Care Act

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1 was for patients like that because birth centers
2 give women an option. Either delivering at a
3 hospital or at home should not be the only
4 two options; birth centers should be somewhere in
5 the middle.

6 I thank you for your time, and I would
7 respectfully ask for our application for a CON to
8 be passed. And thank you; we will take any
9 questions.

10 CHAIRWOMAN SAVAGE: Does the Board or
11 staff have any questions?

12 (No response.)

13 CHAIRWOMAN SAVAGE: One question I have,
14 when it comes your birth center, do you have
15 epidurals or anything like that, or is that
16 typically something that they go to the hospital
17 for if that's what they determine they want?

18 DR. OGUNLEYE: They will have to transfer
19 to the hospital for that.

20 CHAIRWOMAN SAVAGE: Okay. Any other
21 questions?

22 MEMBER MARTELL: I noticed -- and, again,
23 the Alternative Care Act was really to kind of
24 approve access. A couple of the areas that you

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1 identify were part of yours are Harvey, which is
2 one of our high-risk communities in the state.
3 What kind of outreach are you going to do around
4 that community?

5 DR. OGUNLEYE: So one of the things that --
6 I spent some time talking to the manager of Berwyn
7 PCC, and the first thing we need to start is
8 education. There are quite a few patients who may
9 benefit from going to a birth center who don't
10 even know what a birth center is. Even some of my
11 colleagues don't know what a birth center is. So
12 we would love to educate quite a few of the
13 population.

14 Access is always a key, and many patients
15 would love to come to a birth center once they
16 know what a birth center offers. Education is
17 probably also one of the central pieces of
18 patients coming to a birth center, getting a lot
19 of education regarding healthy lifestyles and what
20 they can do and what they can't do in a birth
21 center.

22 MS. WIEGAND: I can also add we also have
23 in our plan that we'll be hiring and have tendered
24 a letter to an outreach, an education coordinator.

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1 And that is primarily their position, to teach
2 classes but also to educate the community on the
3 services that we offer and other services that are
4 available not just within our center but in the
5 community, as well.

6 CHAIRWOMAN SAVAGE: Within the low-risk
7 population, though.

8 MS. WIEGAND: Yes.

9 CHAIRWOMAN SAVAGE: Do you have a
10 lactation consultant that would be on staff?

11 MS. WIEGAND: Yes.

12 CHAIRWOMAN SAVAGE: Other questions?

13 MEMBER MURRAY: I notice in your application
14 that you said you're going to do half of 1 percent
15 charity care. I'm not sure how you're defining
16 that, but that seems pretty low.

17 MS. WIEGAND: So there are no -- there's
18 no previous data on this, and it was our starting
19 point to have a number. It's something we'll
20 develop over time. We will have funds put together,
21 put aside for charity care, but of that particular
22 population everybody I have encountered, they
23 qualify for Medicaid, some type of Medicaid
24 service. So charity care is not really needed,

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1 only for education or classes that are not
2 included within the delivery cost.

3 MEMBER MURRAY: New immigrants need it.

4 MS. WIEGAND: They can still qualify for
5 some plans. I'm not as familiar with Burr Ridge,
6 but in McLean County that particular county has
7 programs set up for them, so they will have other
8 funds available.

9 MS. LORENZ: I'll just add to that. We
10 had lengthy conversations about that very issue,
11 Dr. Murray, and some of it is based on their
12 experiences downstate. Recognizing that it will
13 be a different population to some extent up in the
14 Chicagoland area, you know, we just based it on
15 what we knew with their current operation. But as
16 you'll probably note in the application, we do
17 have a fully outlined charity care policy and plan
18 to comply with that.

19 CHAIRWOMAN SAVAGE: Other questions?

20 (No response.)

21 CHAIRWOMAN SAVAGE: George, if we could
22 have the roll call, please.

23 MR. ROATE: Thank you, Madam Chair.

24 Motion made by Mr. Slater; seconded by

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1 Senator Demuzio.

2 Senator Demuzio.

3 MEMBER DEMUZIO: Yes, based upon the
4 testimony I've heard today and staff report.

5 MR. ROATE: Thank you.

6 Dr. Martell.

7 MEMBER MARTELL: Yes, based on staff
8 report and testimony heard.

9 MR. ROATE: Thank you.

10 Dr. Murray.

11 MEMBER MURRAY: Yes, based on discussion
12 today and the staff report.

13 MR. ROATE: Thank you.

14 Mr. Slater.

15 MEMBER SLATER: Yes, based on testimony
16 and staff report.

17 MR. ROATE: Thank you.

18 Chairwoman Savage.

19 CHAIRWOMAN SAVAGE: Yes, based on staff
20 report and testimony.

21 MR. ROATE: Thank you.

22 That's 5 votes in the affirmative.

23 CHAIRWOMAN SAVAGE: The motion is approved.

24 - - -

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1 CHAIRWOMAN SAVAGE: I hope everyone gets
2 home safely, and now, Ann, we're going to move to
3 your legislative update, please.

4 MS. GUILD: This will be quick. It looks
5 like things are pretty light so far this year, but
6 you never know what's going to happen.

7 The first bill, House Bill 2069, this is
8 the third time we've seen this bill, and it will
9 require us to work in conjunction with IDPH to
10 determine a location for a south suburban trauma
11 center that would be constructed with certain
12 tollway funds. It would also ask us to work in
13 conjunction with IDPH to select a provider for
14 that trauma center to operate it and the resources
15 needed.

16 As I said, we've seen this three times
17 before, and so far it hasn't passed. We've been
18 neutral on it. We do obviously have some concerns
19 because I think the sponsor doesn't understand that
20 you can't just have a freestanding trauma center
21 because there's a lot of other things that go
22 along with being a trauma center.

23 The next bill, House Bill 4122 is new this
24 year, and it takes an act that was many years old,

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1 maybe 10 even, Hospital Basic Services
2 Preservation Act, which was intended to help
3 Rosalind Hospital in Chicago. And it wants to
4 transfer -- it wants to dissolve that board,
5 transfer all the responsibilities to HFSRB.

6 If, in fact, that board has not done
7 anything since Rosalind, and there's no funds in
8 the hospital basic services preservation fund,
9 we're neutral because it may require us to do some
10 rule making, but there's nothing to do under this
11 act. It's an effort by a republican legislator to
12 do a good thing, consolidate government, but he
13 probably should have eliminated that Hospital
14 Basic Service Act completely.

15 I'm going to skip one. House Bill 4431,
16 that's one to pay attention to. That's actually
17 our bill. And, basically, over many years there
18 have been more things that have been added to what
19 can be approved by exemption rather than permit.
20 Last year we saw a little bit of a reversal of
21 that so the things that did require an exemption
22 now require a permit, but we never kept up with
23 the penalties section in the act, and so basically
24 this is going to clarify that for those things

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1 that are largely paperwork, postpermit paperwork
2 violations that would be relevant to a permit, it
3 will be the same for an exemption. So it's pretty
4 simple. And then there's two shell bills to amend
5 the act which may never see any language amended
6 to them but they're out there.

7 If anyone has any questions, I'd be happy
8 to answer them.

9 CHAIRWOMAN SAVAGE: Does the Board have
10 any questions for Ann?

11 MEMBER MARTELL: Can I have a clarification
12 on the last one?

13 MS. GUILD: Senate Bill 2923? It's just a
14 shell. Basically, they write a bill and cross a
15 word out, put the same word back in, put it in in
16 letters rather than numbers, whatever, and it's
17 intended to be amended at some future point in
18 time if needed. That's all it is.

19 MEMBER MARTELL: So has this been proposed
20 or filed?

21 MS. GUILD: It's already been -- it's been
22 filed; it's already assigned to rules committee.
23 I don't know whether it -- or actually, assignments
24 for the last one, Senate bills get assigned to

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1 assignments committee; House bills get assigned to
2 rules, and it's a gateway for bills to get
3 through, and I don't know that -- whether that's
4 going to happen or not. It's just sitting there
5 in a committee that's not a substantive committee.

6 MEMBER MURRAY: I have a generic question.
7 So part of our responsibility is planning, and
8 we've talked about a couple of times where we are
9 on rules, updates, et cetera. So where does that
10 piece come in? Have we looked at what needs to be
11 updated, or do we have suggestions from staff?

12 MS. GUILD: For our rules?

13 CHAIRWOMAN SAVAGE: Like we're talking
14 about the 100-bed rule.

15 MS. GUILD: Oh, yeah, we've actually done
16 some work looking that, and what we haven't looked
17 at so far is what other states are doing for this
18 new transitional care dialysis, but we are working
19 on updating rules.

20 It is a long process because it doesn't stop
21 with us. We can draft rules and then it goes --
22 from us it has to be approved by the governor's
23 office, and there's a review process at JCAR,
24 prefiling review before it can ever get published

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1 for first notice. But we have a lot that's in
2 process.

3 MEMBER MURRAY: So can we get a report or
4 something?

5 MS. GUILD: Sure. Next meeting.

6 MS. AVERY: The last -- was it the
7 September meeting when you did a rules update?
8 They've been lingering for a while, so we will
9 send those via email with a status update. We've
10 done everything that we can do on our part; it's
11 just the governor's office and JCAR.

12 MEMBER MURRAY: That's one question. The
13 second question is, are we doing everything that
14 we ought to do? I have no idea since I don't know
15 what we're doing. So if we could get that.

16 MS. GUILD: We'll make sure you have a
17 complete update at the next meeting.

18 MS. AVERY: I forget when the next meeting
19 is, but we'll go back through the transcripts and
20 pull that along with the report. But we haven't
21 submitted any new rules since that last update
22 that we gave, and I think it was -- was it before
23 the September meeting?

24 MS. GUILD: To be honest, I can't remember.

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1 MS. AVERY: So we'll resend that.

2 MS. GUILD: Right. If it's before you
3 came on the Board --

4 MEMBER MURRAY: I don't remember it since
5 I've been on the Board.

6 MS. GUILD: I'll put something in writing
7 for the next meeting.

8 MS. AVERY: We'll send it out via email.

9 MS. GUILD: Okay. Perfect.

10 MS. AVERY: Because we don't have to take
11 action on it. We'll just kind of update, but if
12 there's changes or rules you'd like Ann to look
13 at, just shoot us an email. But the 100-bed we've
14 been struggling with for years.

15 MEMBER MARTELL: It just seems arbitrary.

16 MS. AVERY: It is. We don't know where
17 the number came from.

18 MEMBER MARTELL: It just seems like a
19 round number.

20 MS. AVERY: It probably was.

21 CHAIRWOMAN SAVAGE: Next on the agenda,
22 our financial report, Courtney.

23 MS. AVERY: Thank you. So you have the
24 financial report in your packet -- or that was

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1 distributed today via email. We have the
2 year-to-date for December 2019. Ken Palmer does this
3 for us from IDPH, as I explained earlier in the year.

4 So each report is year-to-date, a graph of
5 it, expenditure by appropriation. We get a
6 combined appropriation total of \$3.7 million.
7 IDPH support gets 2.5 million, and the Board gets
8 1.2 million. We never spend close to that amount.

9 According to the fiscal staff at IDPH, we
10 will have the same appropriation for fiscal year
11 2021, and if there are any sweeps we won't know
12 ahead of time, but if our fund gets swept to make
13 up any deficits, I'll let you all know.

14 I also want to alert the Board that -- and
15 this fits under the fiscal report -- you will see
16 some salary increases because we now have million
17 dollar people sitting over there. Wave your hands
18 million dollar people, George and Mike.

19 As you know, George and Mike are IDPH staff
20 but union employees, so there was as increase in
21 salary to catch them up from the years behind when
22 we weren't in line with the union contracts and
23 the back pay, so that was put into place.

24 I've been talking to the Chair about your

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1 staff and Rukhaya and myself being projected for
2 raises. I've been in discussions with IDPH, and
3 they wanted to make sure that the Board was aware
4 that we were working on this.

5 So the Chair has given me permission to
6 talk to you all about it. I will send in writing
7 whatever we're proposing. We won't be million
8 dollar people with George and Mike, but we are
9 looking for your support for salary increases.
10 Your staff has not had an increase, Ann since she
11 started, and myself since about 2012. So I don't
12 think it's out of line, but I will send the
13 amounts and the forms prior to submitting them to
14 each and every one of you, and if you can could
15 give me feedback, I would greatly appreciate it.
16 But I just wanted it on the record that you will
17 receive it and if you will agree or not agree, and
18 if I don't hear from you I'll call.

19 MEMBER MURRAY: Will we vote on that?

20 MS. AVERY: No, it's not needed for a
21 vote. I'll probably just go with the traditional
22 3 to 5 percent. It won't be anything outrageous.

23 MEMBER MURRAY: It could be. I'm not
24 asking that. So we don't vote on it?

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1 MS. AVERY: No, we don't vote on it.

2 MEMBER MURRAY: Who does?

3 MS. AVERY: You'll decide but you don't need
4 a collective vote. I just need your feedback on
5 it. If you want to do a vote, we'll do a vote.
6 You can make a motion to say that we don't exceed
7 whatever.

8 MEMBER MURRAY: To me we should vote on it
9 in one of our executive sessions, that's all. It
10 might not be as low as 3 to 5 percent.

11 MS. AVERY: Okay. We can do it in exec in
12 the next meeting, but before -- in the April meeting,
13 but before that time I'll send you the paperwork.

14 MEMBER MURRAY: Okay.

15 MS. AVERY: Thank you.

16 MEMBER SLATER: I know we're short on
17 people in terms of the Board. I will not be able
18 to be at the next meeting.

19 MS. AVERY: We'll have it covered.

20 CHAIRWOMAN SAVAGE: All right. So if there's
21 no other business or questions or concerns, we're
22 going to close our meeting today and thank
23 everybody for your time. And safe travels home.

24 (Off the record at 2:48 p.m.)

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CERTIFICATE OF SHORTHAND REPORTER

I, Paula M. Quetsch, Certified Shorthand Reporter No. 084-003733, CSR, RPR, 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 13th day of March, 2020.

My commission expires: October 16, 2021



Notary Public in and for the
State of Illinois

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