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Transcript of **Full Meeting**

Date: June 21, 2016

Case: State of Illinois Health Facilities and Services Review Board

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ILLINOIS DEPARTMENT OF PUBLIC HEALTH
HEALTH FACILITIES AND SERVICES REVIEW BOARD

OPEN SESSION - MEETING

Bolingbrook, Illinois 60490

Tuesday, June 21, 2016

10:03 a.m.

Job No. 93892

Pages: 1 - 291

Reported by: Melanie L. Humphrey-Sonntag,

CSR, RDR, CRR, FAPR

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A P P E A R A N C E S

BOARD MEMBERS PRESENT:

- KATHY OLSON, Chairperson
- JOEL K. JOHNSON
- DALE GALASSIE
- JUSTICE ALAN GREIMAN
- JOHN MC GLASSON, SR.
- RICHARD SEWELL

EX OFFICIO MEMBERS PRESENT:

- BILL DART, IDPH
- ARVIND K. GOYAL, IHFS

ALSO PRESENT:

- JUAN MORADO, JR., General Counsel
- JEANNIE MITCHELL, Assistant General Counsel
- COURTNEY AVERY, Administrator
- MICHAEL CONSTANTINO, IDPH Staff
- GEORGE ROATE, IDPH Staff

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P R O C E E D I N G S

CHAIRWOMAN OLSON: I'd like to call the meeting to order.

Can we have a roll call, please, George.

MR. ROATE: Thank you, Madam Chair.

Senator Burzynski is absent.

Senator Demuzio is absent.

Mr. Galassie.

(No response.)

MR. ROATE: Is inbound.

CHAIRWOMAN OLSON: On the way.

MR. ROATE: On his way.

Justice Greiman.

MEMBER GREIMAN: Here.

MR. ROATE: He's here.

Mr. Hayes is absent.

Mr. Johnson.

MEMBER JOHNSON: Here.

MR. ROATE: Mr. McGlasson.

MEMBER MC GLASSON: Yes, sir.

MR. ROATE: Mr. Sewell.

MEMBER SEWELL: Here.

MR. ROATE: Madam Chair.

CHAIRWOMAN OLSON: Here.

1 MR. ROATE: That makes five in attendance
2 so far.

3 CHAIRWOMAN OLSON: Thank you, George.
4 The first order of business is executive
5 session.

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

9 MEMBER SEWELL: So moved.

10 MEMBER JOHNSON: Second.

11 CHAIRWOMAN OLSON: All those in favor
12 say aye.

13 (Ayes heard.)

14 CHAIRWOMAN OLSON: Opposed, like sign.

15 (No response.)

16 CHAIRWOMAN OLSON: We are now in executive
17 session for about 20 minutes, so I need everybody to
18 clear the room, please.

19 (At 10:04 a.m. the Board adjourned into
20 executive session, during which Member Galassie
21 joined the proceedings. Open session proceedings
22 resumed at 10:34 a.m. as follows:)

23 CHAIRWOMAN OLSON: Okay. We're back in
24 session.

1 Is there business to come out of the
2 executive session?

3 MR. MORADO: Yes, there is, Madam Chair.

4 We're going to be seeking a final order on
5 HFSRB 16-01, the Albany Park Medical Surgical
6 Center.

7 CHAIRWOMAN OLSON: May I have a motion to
8 accept this final order.

9 MEMBER GALASSIE: So moved.

10 CHAIRWOMAN OLSON: And a second.

11 MEMBER GREIMAN: Second.

12 CHAIRWOMAN OLSON: All those in favor
13 say aye.

14 (Ayes heard.)

15 CHAIRWOMAN OLSON: Opposed, like sign.

16 (No response.)

17 CHAIRWOMAN OLSON: Motion passes.

18 MR. MORADO: We're also seeking a final
19 order on HFSRB 16-04, Decatur Memorial Hospital,
20 also known as Project No. 14-046.

21 CHAIRWOMAN OLSON: May I have a motion to
22 accept this final order.

23 MEMBER SEWELL: So moved.

24 CHAIRWOMAN OLSON: And a second.

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1 MEMBER MC GLASSON: Second.

2 MEMBER GALASSIE: Second.

3 CHAIRWOMAN OLSON: All those in favor
4 say aye.

5 (Ayes heard.)

6 CHAIRWOMAN OLSON: Opposed, like sign.

7 (No response.)

8 CHAIRWOMAN OLSON: Motion passes.

9 MR. MORADO: Next, we have a final order on
10 HFSRB 16-05. This is the 2014 Health, LLC, doing
11 business as Chicago Behavioral Health. This was
12 also known as Exemption Application E-016-14.

13 CHAIRWOMAN OLSON: May I have a motion to
14 approve this final order.

15 MEMBER GREIMAN: So moved.

16 CHAIRWOMAN OLSON: Moved by Justice Greiman.

17 A second.

18 MEMBER GALASSIE: Second.

19 CHAIRWOMAN OLSON: All those in favor
20 say aye.

21 (Ayes heard.)

22 CHAIRWOMAN OLSON: Opposed, like sign.

23 (No response.)

24 CHAIRWOMAN OLSON: The motion passes.

1 MR. MORADO: Finally for final orders, we
2 have one, HFSRB 16-06. That's for Luther Oaks,
3 Incorporated, also known as Permit No. 13-067.

4 CHAIRWOMAN OLSON: May I have a motion to
5 approve this final order.

6 MEMBER JOHNSON: So moved.

7 CHAIRWOMAN OLSON: And a second, please.

8 MEMBER GALASSIE: Second.

9 CHAIRWOMAN OLSON: All those in favor
10 say aye.

11 (Ayes heard.)

12 CHAIRWOMAN OLSON: Opposed, like sign.

13 (No response.)

14 CHAIRWOMAN OLSON: The motion passes.

15 MR. MORADO: And I have one more for
16 referral because -- you can do all these in
17 one motion.

18 I'm asking for referrals to legal counsel
19 for Permit No. 13-067, Exemption No. E-023,
20 Exemption No. E-007-13, and Exemption E-016-14.

21 CHAIRWOMAN OLSON: May I have a motion to
22 approve these referrals to legal counsel.

23 MEMBER MC GLASSON: So moved.

24 MEMBER GREIMAN: Second.

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1 CHAIRWOMAN OLSON: And a second.

2 All those in favor say aye.

3 (Ayes heard.)

4 CHAIRWOMAN OLSON: The motion passes --

5 I'm sorry. Anybody opposed?

6 (No response.)

7 CHAIRWOMAN OLSON: Motion passes.

8 Okay. The next order of business is

9 approval of the agenda.

10 May I have a motion to approve the

11 June 21st, 2016, agenda.

12 MEMBER GALASSIE: So moved.

13 CHAIRWOMAN OLSON: And a second.

14 MEMBER SEWELL: Second.

15 CHAIRWOMAN OLSON: All those in favor

16 say aye.

17 (Ayes heard.)

18 CHAIRWOMAN OLSON: Opposed?

19 (No response.)

20 CHAIRWOMAN OLSON: The motion passes.

21 May I have a motion to approve the

22 transcripts of the May 10th, 2016, meeting.

23 MEMBER GALASSIE: So moved.

24 CHAIRWOMAN OLSON: And a second, please.

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MEMBER SEWELL: Second.

CHAIRWOMAN OLSON: All those in favor
say aye.

(Ayes heard.)

CHAIRWOMAN OLSON: Opposed?

(No response.)

CHAIRWOMAN OLSON: The motion passes.

- - -

1 CHAIRWOMAN OLSON: The next order of
2 business is public participation.

3 Jeannie.

4 MS. MITCHELL: You will be called up in
5 groups of five. You do not have to speak in the
6 order in which you are called. When you are called
7 up, please go to the table on your left, our right.

8 The first five, first is Aaron Shepley for
9 Transformative Health in McHenry. Second is Edward
10 Goldberg, also for Transformative Health in McHenry.

11 Next is Phil Schaefer for Southern Illinois
12 Gastrointestinal Endoscopy Center. Also for that
13 project is Bart Millstead and Fred Hall.

14 Since you're not all speaking on the same
15 project, please indicate which project you are
16 speaking on.

17 CHAIRWOMAN OLSON: And, George, I would ask
18 that you tell me in your loud voice when their
19 two minutes are up.

20 MR. ROATE: Yes, ma'am.

21 MR. CONSTANTINO: Would you all please
22 sign in.

23 MS. MITCHELL: As Mike said, please remember
24 to sign in.

1 MR. CONSTANTINO: And if you have written
2 documents, if you could provide me with your written
3 comments for the court reporter.

4 THE COURT REPORTER: Thank you.

5 CHAIRWOMAN OLSON: Mr. Shepley, you can
6 proceed.

7 MR. SHEPLEY: Thank you very much.

8 Good morning, ladies and gentlemen of the
9 Board. My name is Aaron Shepley. I am here on
10 Project No. 15-44, the request from Transformative
11 Health of McHenry for a CON to create an acute
12 care -- or a postacute care facility in McHenry.

13 I am the general counsel and president of
14 insurance services for Centegra Health System, and
15 we're here today for two reasons: Number one,
16 I wish to express our unequivocal -- Centegra's
17 unequivocal -- I can't get it out -- unequivocal
18 support for this project. It's going to enhance
19 access to care for members of our community. It's
20 going to help us to continue to keep people close to
21 home.

22 It will not diminish Centegra Health
23 Systems' long-standing relationship with other
24 long-term care providers in the area and -- you

1 know, for example, in calendar year 2014 alone, we
2 had 750 of our patients who were required to get
3 postacute care services outside of McHenry County,
4 so this will help to eliminate that issue.

5 Number two and more importantly, I want to
6 make sure that members have a full understanding of
7 what Centegra's role in this project is and is not.
8 I want to make clear that, while we have unequivocal
9 support for this project, this is not Centegra's
10 project.

11 Centegra has no ownership or other financial
12 interest in any Applicant, there is no mortgage or
13 loan being given by Centegra for any Applicant,
14 there is no sale of the property that's -- on which
15 this project is proposed to be located.

16 The only relationship that we have to this
17 project, other than its siting on our campus, is
18 that we will have a long-term land lease that will
19 involve nominal annual payments to Centegra. There
20 is no other financial connection whatsoever to this
21 project by Centegra Health.

22 MR. ROATE: Two minutes.

23 CHAIRWOMAN OLSON: Thank you.

24 MR. SHEPLEY: We hope you will support it.

1 Thank you.

2 CHAIRWOMAN OLSON: Thank you.

3 MS. MITCHELL: Mr. Goldberg, you can go
4 next.

5 MR. GOLDBERG: Thank you.

6 Good morning, Madam Chairman and respected
7 members of the Board. Thank you for allowing me the
8 opportunity to speak before you today in support of
9 Transformative Health of McHenry.

10 My name is Edward M. Goldberg, and I was a
11 hospital administrator for 38 years. I was the
12 president of the St. Alexius Medical Center in
13 Hoffman Estates for 18 years, from July 19th, 1994,
14 until November 2nd, 2012. I retired due to being
15 diagnosed with incurable large B-cell lymphoma.
16 I am here today to encourage you to vote in favor of
17 Project No. 15-044.

18 I've known the managers and owners of this
19 project since early 2008 when they approached me to
20 receive my input in developing a new project and
21 have required -- and they subsequently appointed me
22 to be a member of their community advisory board in
23 late 2008. This transitional care facility, the
24 Claremont of Hanover Park, opened in 2010.

1 Having an incurable disease, I have to face
2 the reality of seeking out a facility where my
3 cancer causes me to require skilled nursing
4 facilities. Although I live in Deerfield, Illinois,
5 31 miles from St. Alexius Medical Center and
6 35 miles from the Claremont, I want to be at a
7 facility that allows me to be transferred to
8 St. Alexius where all of my physicians practice.

9 To provide for some perspective, there are
10 118 nursing skilled facilities within a 30-minute
11 drive of St. Alexius Medical Center. When
12 necessary, I will choose to go to the Claremont
13 because of the consistent positive feedback I heard
14 from patients who utilized the facility and then
15 returned to my hospital, St. Alexius. Their
16 comments focused on tangibles, such as cleanliness
17 of the facility, decor, homelike amenities,
18 friendliness of staff, and competencies of the
19 medical, nursing, and therapy teams.

20 I also took notice of their intangible
21 comments that focused on the holistic healing
22 environment for which the Claremont is known.
23 During a recent tour of the Claremont, the facility
24 looked exactly the same as when it opened.

1 I strongly encourage the Board to approve --

2 MR. ROATE: Two minutes.

3 MR. GOLDBERG: Thank you.

4 CHAIRWOMAN OLSON: You can finish your
5 sentence.

6 MR. GOLDBERG: -- the Transformative Health
7 Care of McHenry project. It is patterned after the
8 Claremont and, as such, represents the future of
9 health care.

10 Thank you very much.

11 CHAIRWOMAN OLSON: Thank you.

12 Next, please.

13 MR. SCHAEFER: Good morning.

14 CHAIRWOMAN OLSON: And be sure you tell us
15 your project so --

16 MR. SCHAEFER: Yes.

17 Southern Illinois Gastrointestinal Endoscopy
18 Center, Project 15-061.

19 Good morning. My name is Philip Schaefer.
20 I'm the vice president and administrator for
21 Southern Illinois Healthcare. We're a
22 three-hospital system headquartered in Carbondale,
23 Illinois.

24 I'm here to express opposition to this

1 project and specifically to refute some of the
2 claims made by the Applicant's attorney in
3 communications during the project review.

4 The Applicant claims he needs to establish
5 his own ASTC in order to retain his patients because
6 SIH's employed physicians are penalized for
7 referring SIH physicians [sic] to him for
8 gastrointestinal services. That's not the case and
9 I personally know of many referrals to
10 Dr. Makhdoom's clinic from SIH physicians, including
11 since he resigned from our medical staffs.

12 Each employed physician's contract with us
13 states that patients may be referred to physicians
14 outside of SIH by any patient's request, and no
15 physicians are penalized in any such way for making
16 referrals.

17 While the Applicant's attorney claims that
18 Dr. Makhdoom treats all patients regardless of their
19 ability to pay through the offer of free screenings
20 and reduced cost-assist programs, these programs
21 provide very little benefit to the residents of
22 southern Illinois.

23 For example, his offer of 5 free
24 colonoscopies a month to patients of a local health

1 center provides a grand total of 60 screenings
2 a year out of the 15,000 total colonoscopies that
3 patients receive who reside in our area.

4 Those patients who do not have insurance and
5 are not lucky enough to be one of the 60 must pay a
6 \$1500 fee if they qualify for his free colonoscopy
7 assistance program. Last year only 10 percent of
8 his patients received this discounted rate.

9 In her April 7th letter to the Board, the
10 Applicant's attorney projects 5 percent Medicaid
11 revenue and no charity care for the proposed
12 facility while the existing ASTCs in the area have
13 reported 19 percent Medicaid. Since 28 percent of
14 our area residents are Medicaid recipients, the
15 Applicant will provide very little care to our most
16 vulnerable population.

17 Given the proposed payer mix for this
18 facility, the Applicant's assertion that the program
19 is designed to improve colorectal cancer screening
20 rates in southern Illinois targeting uninsured and
21 underinsured is a gross exaggeration.

22 Finally, unlike the Applicant, SIH and the
23 SIH Medical Group provide care to all patients
24 regardless of their ability to pay. We turn away no

1 one because of inability to pay. We are safety net
2 providers for patients who not only need
3 screening --

4 MR. ROATE: Two minutes.

5 CHAIRWOMAN OLSON: Please conclude.

6 MR. SCHAEFER: -- who need screening
7 procedures but also complex medical treatments of
8 gastrointestinal abnormalities or complications.

9 Thank you.

10 CHAIRWOMAN OLSON: Thank you.

11 Do you want to pass the mic? Make sure you
12 get that close to your mouth so we can hear real
13 well.

14 MR. MILLSTEAD: Hello. I'm with the same
15 project.

16 Good morning. My name is Bart Millstead.
17 I'm the administrator of Memorial Hospital of
18 Carbondale, and I would like to express my
19 opposition to the Southern Illinois Gastrointestinal
20 Endoscopy Center project and comment on some of the
21 claims that were made in the materials provided for
22 this project.

23 First, Dr. Makhdoom resigned from the
24 medical staffs at both Memorial Hospital at

1 Carbondale and our sister hospital, St. Joseph's
2 Memorial Hospital in Murphysboro, in 2015 when he
3 elected not to fulfill the medical staff bylaws
4 requirement that physicians who perform procedures
5 in those hospitals must take emergency room and
6 after-hours call.

7 In her May 16th letter to the Board, the
8 Applicant's attorney stated that our hospitals would
9 not allow him to see his own patients during call
10 coverage and that he was not allowed follow-up on
11 emergency patients he saw during his call period.

12 These assertions are completely untrue.
13 Like every other physician on our medical staff, as
14 long as he has privileges, he has the ability to see
15 his own patients and to follow up with those
16 patients during such call coverage times.

17 Secondly, the assertions that the project
18 will not adversely impact any of the other health
19 care providers in our area is also untrue.
20 Dr. Makhdoom's resignation from our facilities'
21 medical staffs and the relocation of his endoscopy
22 caseload to his own practice has already had a
23 significant impact on our facilities at SIH.

24 Lastly, as health care professionals, we're

1 most concerned about the Applicant's apparent
2 disregard for patient safety. The Applicant does
3 not have and has not requested a transfer agreement
4 with a hospital within 15 minutes of travel time of
5 his facility, which is required for ASTC licensure.

6 His attorney stated in an April 7th letter
7 to the State Board that the solution to the
8 inevitable emergency is to simply call 911 and have
9 the patient taken to the nearest emergency room.
10 Dr. Makhdoom apparently intends to abandon patients
11 in an emergency situation and not be part of the
12 continuum of care.

13 Thank you.

14 CHAIRWOMAN OLSON: Thank you.

15 Next.

16 MR. HALL: Good morning. I'm on the same
17 project, 15-061.

18 Good morning. My name is Fred Hall, and I'm
19 perioperative services manager at St. Joseph's
20 Memorial Hospital in Murphysboro. I'm here to
21 present testimony in opposition to the application
22 submitted for the Southern Illinois Gastrointestinal
23 Endoscopy Center.

24 I worked alongside the Applicant,

1 Dr. Makhdoom, for many years as both a nurse and a
2 manager until he resigned his hospital privileges in
3 2015. In a letter that Dr. Makhdoom's attorney sent
4 the Board during project review, she claimed that he
5 resigned from SIH hospital staffs because he became
6 concerned he would lose block time. The reality is
7 that he had block time at two of our hospitals with
8 regular block time at St. Joseph's four days a week
9 for eight hours each day.

10 To further accommodate his endoscopy volume,
11 St. Joseph's recently added two additional GI
12 procedure rooms. During construction Dr. Makhdoom
13 began to greatly reduce his surgical caseload at
14 St. Joseph's and scheduled most of his patients at
15 his office-based practice. Those patients that he
16 did bring to the hospital were almost entirely
17 Medicaid or uninsured.

18 Prior to his resignation, his block time was
19 never reduced or reallocated. It remained open and
20 available to him regardless of whether he used it
21 or not.

22 The new rooms were completed shortly before
23 his resignation, and since his resignation the
24 GI procedure rooms at St. Joseph's operate

1 significantly below target utilization. For
2 Dr. Makhdoom's attorney to claim that the other
3 hospitals have limited scheduling slots and cannot
4 accommodate the volume that he can perform is
5 untrue.

6 The statement that his facility will not
7 impact other providers or health care facilities is
8 also untrue, as his office-based facility has
9 already had a very negative impact on my hospital,
10 which will only increase if you approve the proposed
11 project.

12 Thank you for allowing me the time to
13 address my concerns today.

14 CHAIRWOMAN OLSON: Thank you.

15 Jeannie.

16 MS. MITCHELL: The next five, please come up
17 when called.

18 First is for Southern Illinois
19 Gastrointestinal Endoscopy Center, Project
20 No. 15-061, Joe Ann Troue. For that same project,
21 Carole Klaine. Again for the Southern Illinois
22 Gastrointestinal Endoscopy Center project,
23 Cathy Blythe.

24 And for Northbrook Behavioral Hospital,

1 Project No. 16-011, Tina Cooper and Reverend
2 Tom Beckstrom.

3 Please do not forget to sign in.

4 CHAIRWOMAN OLSON: You don't have to sign in
5 before you speak; just make sure you sign in before
6 you leave the table. So whoever is ready can please
7 start.

8 Somebody please start.

9 MS. BLYTHE: Hi. This is for Project 15-061,
10 Southern Illinois Gastrointestinal Endoscopy Center.

11 Good morning. My name is Cathy Blythe, and
12 I'm the system planning manager for Southern
13 Illinois Healthcare in Carbondale. I'm presenting
14 testimony in opposition to the Southern Illinois
15 Gastrointestinal Endoscopy Center project.

16 As the staff report documents, the proposed
17 ASTC is not necessary to improve access for health
18 care services, it will result in an unnecessary
19 duplication of services, and it will have a negative
20 impact on other ASTCs and hospitals in the area that
21 currently provide endoscopy services.

22 Of the nine licensed facilities providing
23 endoscopy procedures in the target market area, five
24 are operating significantly below target utilization

1 levels. Physicians Surgery Center -- which is
2 identified as Carbondale Clinic ASTC in the staff
3 report located just minutes away from the
4 Applicant's office which is the proposed site of the
5 ASTC -- has a procedure room that is currently
6 operating at 25 percent capacity as well as
7 two operating rooms that are operating below the
8 target occupancy level.

9 Additionally, hospital profiles for 2015
10 document that St. Joseph's Memorial Hospital in
11 Murphysboro, which is only seven minutes away from
12 the proposed site, experienced 27 percent occupancy
13 in its GI procedure rooms in 2015.

14 State Board rules permit only endoscopic
15 procedures performed at a licensed health care
16 facility to be used to justify the approval of a new
17 ASTC. The application does not present a sufficient
18 historic volume to justify the establishment of a
19 new ASTC.

20 Additionally, the projected number of cases
21 to be performed in the facility, based on historic
22 procedures, will not justify the two procedure rooms
23 requested. During the last two years, the Applicant
24 only performed 462 procedures in a licensed health

1 care facility. The remaining were done -- performed
2 in his office, which the CON rules do not accept as
3 justification for the need to establish an
4 additional facility.

5 I respectfully ask the Board to take these
6 facts into account when considering the application.

7 Thank you.

8 CHAIRWOMAN OLSON: Thank you.

9 Next.

10 MS. COOPER: Hello. I am Tina Cooper, the
11 director of resident services at Brookdale
12 Northbrook retirement community, and I am here to
13 speak on behalf of Project 16-011. I am here to
14 testify today since my written letter of support was
15 not previously considered by the Board.

16 For the 12 years that I have been the
17 director of resident services in Northbrook, it has
18 always been a struggle to obtain both inpatient and
19 outpatient senior psychiatric care, specific for
20 seniors. Often there are no beds available or not
21 an appropriate bed available for the senior mental
22 health.

23 The behavioral health unit in Des Plaines is
24 small and most commonly full. That is our nearest

1 facility. When available beds are available, they
2 are not often nearby. I've had residents sent as
3 far away as Hoffman Estates and Christ Hospital in
4 Oak Lawn to receive treatment.

5 Continuity of care suffers when the care
6 team, family, and local current physicians are not
7 able to participate in care due to the senior being
8 removed from their area.

9 A recent example of many situations I have
10 seen -- I will call this person Marsha. She was
11 74 years old and had three admissions to psychiatric
12 facilities in less than two years. She was admitted
13 to Evanston, Lutheran Geneva, and the last time
14 admitted to Christ Hospital because no beds were
15 available in the area.

16 Marsha had no family and her support system
17 was not able to follow her progress well at Christ
18 Hospital. She had no clothes there, no one
19 available to take them that far to her, and she was
20 forced to wear donated clothing while there, which
21 further crushed her spirit. She tearfully said to
22 me once while I spoke to her on the phone, "I look
23 like a homeless beggar."

24 Marsha had three different psychiatric care

1 teams in less than two years, causing poor
2 continuity of care, and varying medications which
3 were changed by each new care team. No good plan
4 ever resulted. It did, however, result --

5 MR. ROATE: Two minutes.

6 MS. COOPER: -- in her being admitted to
7 assisted living and then a locked-down memory care
8 facility with dementia patients --

9 CHAIRWOMAN OLSON: I need you to conclude
10 your remarks.

11 MS. COOPER: -- where she, sadly, remains
12 today.

13 CHAIRWOMAN OLSON: Thank you.

14 MS. COOPER: Thank you.

15 REVEREND BECKSTROM: Good morning. My name
16 is Tom Beckstrom. I'm the lead pastor at the
17 Northbrook Evangelical Covenant Church, and I'm here
18 in support of the Northbrook Behavioral Hospital,
19 Project No. 16-011.

20 We are a relatively small congregation.
21 I've been in Northbrook for six years. Whenever we
22 see a need, we try to meet that need. I have been
23 surprised at the number of times our church has been
24 involved in the care of people with behavioral

1 health issues.

2 There have been six teens or preteens and
3 three young adults that have been related to our
4 church in these six years. One experience,
5 I received a text saying, "Good-bye. Tell my mom
6 I love her." My wife and I, while calling for help,
7 were racing to her location where we were able to
8 talk her to safety.

9 We took her out to dinner, so calmly as we
10 talked, I said, "You realize I have to take you now
11 to the hospital."

12 She said, "Thank you. I don't have the
13 strength to go there by myself."

14 My wife and I sat with her half the night in
15 the ER as we waited for a room, and for the next
16 two days she sat in what is called a safe room from
17 the operat- -- or from the emergency room until she
18 was able to be transferred to a facility where they
19 found a room for her.

20 I've also been called in by parents with
21 kids who have been cutting themselves, harming
22 themselves, abusing drugs, or attempting to take
23 their lives in other ways. In all these cases we
24 have ended up in the emergency room and then wait

1 for a space where they could accommodate them. One
2 time it was a horrific scene of a child setting
3 himself on fire.

4 If our church of only 150 people has had
5 9 people in nine years that we have been in contact
6 with, I can verify there is a need in the North
7 Shore and we would welcome it in Northbrook.

8 I also believe in miracles. And one is you
9 put a microphone in front of a pastor and say
10 "You've got two minutes," and I've said everything
11 I needed to say.

12 Thank you for listening.

13 MR. ROATE: Two minutes.

14 CHAIRWOMAN OLSON: It's a miracle.

15 Next.

16 MS. KLAINNE: Hi. My name is Carol Klaine,
17 and I am a patient of Dr. Makhdoom, and I am here on
18 behalf of his application for an endoscopy center in
19 Jackson County, Illinois.

20 I can sum up my relationship with
21 Dr. Makhdoom and -- he saved my life and it is a
22 privilege to be here and speak with you on his
23 behalf today.

24 I grew up in Jackson County, and I know that

1 it is a very poor county. And, actually, it's the
2 poorest county in the state of Illinois. I know
3 that he serves many people that are underinsured or
4 have no insurance at all and his generosity to each
5 one of those patients in caring for them.

6 The project will support early diagnosis and
7 treatment for colon cancer and allow Dr. Makhdoom to
8 continue to provide the type of excellent care that
9 I received from him. I can say that for myself.

10 Jackson County has a population of over
11 60,000 with a median income of \$33,000. Many
12 members of our community are either uninsured or
13 underinsured -- for example, they have insurance and
14 high deductibles -- and I know him to be one to
15 allow people to come in whether they have insurance
16 or not.

17 He's a kind man and has shown the community
18 and demonstrated many times how much he supports
19 southern Illinois and the constituents that live in
20 that area. I urge you today to vote yes on this
21 project.

22 Thank you for your time.

23 CHAIRWOMAN OLSON: Thank you.

24 Next.

1 MS. TROUE: Good morning. My name is
2 Joe Ann Troue, and I am a patient of Dr. Makhdoom's.
3 I have been for about 15 years.

4 I have Crohn's disease; I've had it for
5 45 years. And he has taken care of me. I have his
6 cell phone, if you can imagine, and he -- he has
7 taken care of me. I mean, no matter what, when he
8 was in the middle of dinner, whatever. He's a very
9 caring person. He is -- he wants to care for the
10 patient. That's his main objective, is to get the
11 patient the help that they need.

12 He takes care of my whole family, and
13 it's -- he's -- I'm just here in his behalf for
14 Project 15-061.

15 And that's all I have to say.

16 CHAIRWOMAN OLSON: Thank you.

17 Next, Jeannie.

18 MS. MITCHELL: The next five are all
19 speaking on Project 16-011, Northbrook Behavioral
20 Hospital, and they are Nancy Brown, Dr. Shiraz Butt,
21 Anthony Bunin, Dr. Joe Troiani, and Dr. David Bawden.

22 Please sign in. You do not have to sign in
23 before you begin speaking, just before you leave the
24 table. And if you have written comments, please

1 hand them to Mr. Constantino.

2 You can begin speaking.

3 CHAIRWOMAN OLSON: Please begin. You don't
4 have to sign in before you begin. Just somebody
5 grab a mic and let's go.

6 Thank you.

7 DR. BUTT: Good morning. My name is
8 Shiraz Butt. I'm a psychiatrist and I'm practicing
9 in the area for over 15 years. I'm speaking in
10 support of the project, the Northbrook Behavioral
11 Hospital.

12 And what I've come across is a severe
13 shortage of services in the area. I've come across
14 examples of patients and their families not being
15 able to access severely needed mental health
16 services. I have seen patients languish in
17 emergency rooms because they were not able to find
18 psychiatric beds.

19 And I know on paper sometimes you see there
20 are a lot of psychiatric beds, but what these
21 patients' needs are -- what these patients need are
22 specialized services, and many times community
23 hospitals are not able to meet their needs, so --
24 I'll give you a recent example of a 16-year-old

1 autistic boy who had to wait two days in the
2 emergency room. He had presented with severe
3 aggression, was hitting himself, engaged in severe
4 property destruction. And the emergency room was
5 not able to find a bed for this child, and so they
6 had to let the family go back home after medicating
7 the child.

8 Now, these are patients who are at risk of
9 harm to themselves and others. We're talking about
10 suicidal patients, patients with addictions who need
11 detox. And by not being able to provide services
12 for them, we are not only placing themselves -- them
13 at risk but also society at large. I also have
14 numerous colleagues who have brought this to my
15 attention, and I keep getting calls from them
16 because they're not able to find psychiatric beds
17 for their patients.

18 We also have a shortage in terms of
19 continuity of care issues. So once the patient's
20 discharged from the hospital, we're not able to find
21 services close their home, and, as such, the
22 families have to travel 50, 60 miles to either go to
23 see a psychiatrist or go for other, less-intense
24 services like intensive outpatient programs or

1 larger hospital programs.

2 Also, we have seen that there is an overall
3 increase in the --

4 MR. ROATE: Two minutes.

5 DR. BUTT: -- increase in the prevalence of
6 mental disorders locally and nationally.

7 CHAIRWOMAN OLSON: Thank you.

8 Next.

9 MS. NANCY BROWN: Hello. My name is
10 Nancy Brown.

11 CHAIRWOMAN OLSON: You're going to need to
12 pull that much closer.

13 MS. NANCY BROWN: Hello. My name is
14 Nancy Brown, and I'm the president of Meier Clinics
15 Foundation, the business management services
16 division of Meier Clinics. I am here in support of
17 the Northbrook Behavioral health hospital in 16-011.

18 Meier Clinics has provided mental health
19 care services in Illinois for 30 years in Wheaton,
20 Northbrook, Geneva, and Chicago. We provide
21 approximately 2400 outpatient sessions per month.

22 I am here representing Meier Clinics and
23 Dr. Gary Casaccio, our medical director. He is very
24 supportive of HealthVest's request for approval of a

1 behavioral health hospital in Northbrook. I have a
2 letter that Dr. Casaccio has signed. This letter
3 was not previously recognized when letters of
4 support were sent.

5 Some of Dr. Casaccio's letter includes the
6 following information: "It is not unusual for our
7 patients to experience frequent delays in accessing
8 inpatient care, often -- inpatient psychiatric
9 care -- often due to bed shortages or lack of
10 services."

11 US HealthVest is also known as a hospital
12 who uniquely offers specific hospital-unit programs
13 such as one specifically designed for military
14 members who are struggling with posttraumatic stress
15 syndrome or other emotional issues, a women's
16 program specifically designed for women who have had
17 trauma in their background, and a faith-based
18 program for those who want to work on their physical
19 and emotional aspects of care along with their
20 spirituality.

21 Our staff solicited feedback from several of
22 our medical and clinical staff. Together we
23 reported that we have referred approximately
24 66 people to inpatient care over the last 12 months.

1 This is not reflective of the total number we have
2 referred, as we have over 50 clinical staff in
3 Illinois, so the above is a very conservative
4 figure. The estimated number of patient referrals
5 over a 24-month period after the project is
6 completed would conservatively be 122 people.

7 I encourage you to support the approval of
8 US HealthVest's application --

9 MR. ROATE: Two minutes.

10 MS. NANCY BROWN: -- and are in complete
11 support of it.

12 Thank you very much.

13 CHAIRWOMAN OLSON: Thank you.

14 DR. BUNIN: Yes. Hello. My name is
15 Anthony Bunin. I'm a psychologist in practice in
16 the Chicagoland area for the last 15 years,
17 providing services to -- care of psychiatric
18 patients in the area and wanted to offer my support
19 for Project 16-011.

20 My sentiments echo many of the sentiments of
21 the other individuals. It turns out the lack of
22 access for inpatient psychiatric beds and
23 specialized -- the care of this particular
24 population, which is a very specific population,

1 differentiated from other traditional psychiatric
2 populations.

3 There's a significant lack of available
4 beds, as other individuals have mentioned,
5 oftentimes because individuals have to travel one to
6 two hours to find placement at a facility and
7 oftentimes now are using the emergency room as a
8 conduit to provide psychiatric services for this
9 population.

10 As such, there's a real lack of appropriate
11 services, yet a need for access in the local
12 communities for this very needy population, which is
13 demographically the largest growing population of
14 this -- certainly, the segment of the population
15 that's growing substantially.

16 Just in terms of general information,
17 there's been an 800 percent increase over the last
18 10 years in the use of emergency rooms for general
19 psych crises nationally due to a lack of specific
20 inpatient beds for this population, so the need for
21 specialized programming, for the understanding of
22 the comorbid medical conditions that many of these
23 elderly individuals present, it is -- is a desperate
24 need of the community currently and would be

1 serviced well through the support of this project.

2 CHAIRWOMAN OLSON: Next.

3 DR. TROIANI: I'm Dr. Joe Troiani. I am
4 director of behavioral health programs for Will
5 County health department. I also chair the Will and
6 Grundy County LAN. It's a collaboration of
7 community behavioral health providers in Grundy and
8 Will County who have been meeting monthly since
9 June of 1993.

10 I can't emphasize the critical shortage of
11 psychiatric beds in the area. We maintain
12 two crisis programs, and there have been weekends,
13 for example, where the closest psychiatric bed for
14 an adolescent was Champaign, Illinois, which is
15 almost four hours away from us. This has resulted
16 from the closure of psychiatric beds, dramatic
17 downsizing since 1992. We've also had the closure
18 of State psychiatric hospitals, Tinley Park. The
19 other psychiatric hospitals have also seen a
20 downsizing of beds and, of course, with the current
21 fiscal crisis, the downsizing in capability.

22 What we don't want is the default mental
23 health system to be the prisons. In Joliet they're
24 going to be opening up the Joliet Mental Health

1 Center, which is Illinois Department of Corrections.
2 It will be a complete mental health facility. We
3 don't need the emergency rooms and the prisons to be
4 the default service providers.

5 And in my other hat I'm a retired commander
6 of the United States Navy, having served
7 32 1/2 years. I'm critically aware of the shortage
8 of psychiatric beds for those who have served or
9 even those who are serving as well as their
10 families. Yes, we have Great Lakes; yes, we have
11 the VA center; but the ability to access services is
12 quite a challenge because of the large number of
13 people seeking services, so the availability of
14 psych beds and specialty programs such as we have in
15 Chicago Behavioral health hospital is of critical
16 importance.

17 Thank you.

18 CHAIRWOMAN OLSON: Thank you.

19 DR. BAWDEN: I'm Dr. David Bawden. I'm a
20 psychiatrist. I've been in practice 40 years in
21 the Chicago area, currently specializing in
22 geropsychiatry.

23 I think personally, if we asked everyone in
24 the room, "Have you had someone -- a parent, uncle,

1 aunt -- who has had psychiatric problems,
2 geropsychiatric problems?" most of us would raise
3 our hands. We've all had personal experience
4 with it.

5 It's difficult to get enough beds. Even
6 last night -- I have availability of 50 beds around
7 the area. I could not get a geropsychiatric patient
8 in any of my beds. About a year ago I started the
9 18-bed geropsychiatric unit at Chicago Behavioral
10 Hospital, who are full most of the time.

11 I go to several nursing homes. There are
12 always requests for admissions of patients with
13 behavioral disturbances. I think that the
14 demographics are very compelling. This is only
15 going to become a larger and larger need as time
16 goes on.

17 And, you know, it's -- first of all, you get
18 your AARP card and you realize you're moving in that
19 direction. Then you get on social security and you
20 know you're really moving in that direction.

21 So, personally, we're all going to need
22 these kind of services at some point, and it's our
23 opportunity to try and build them out not only for
24 our families but for ourselves.

1 Thank you very much.

2 CHAIRWOMAN OLSON: Thank you.

3 Next, please.

4 MS. MITCHELL: The next five will also be
5 speaking on Project 16-011, Northbrook Behavioral
6 Hospital.

7 Dr. Thodur Ranganathan, Kasia Wereszczynska,
8 Alfa Murphy, Dr. Edgar Ramos, and Dr. Tony DeJoseph.

9 Please do not forget to sign in. You do not
10 have to sign in before you begin speaking.

11 CHAIRWOMAN OLSON: Who are we missing?

12 Did you call five?

13 MS. MITCHELL: I did.

14 CHAIRWOMAN OLSON: Last chance.

15 DR. DE JOSEPH: Dr. Ramos had a medical
16 procedure. He couldn't make it.

17 CHAIRWOMAN OLSON: Okay. Thank you.

18 MS. MITCHELL: Thank you.

19 CHAIRWOMAN OLSON: Please go ahead.

20 DR. DE JOSEPH: I'm Tony DeJoseph. I'm the
21 CEO of Chicago Behavioral Hospital and --

22 THE COURT REPORTER: Can you speak closer?
23 I can't hear you.

24 DR. DE JOSEPH: Tony DeJoseph, CEO of

1 Chicago Behavioral Hospital here in support of
2 Northbrook Behavioral Hospital.

3 I want to talk about the environment right
4 now for psychiatric care in Illinois. We're looking
5 at cuts to a wide variety of outpatient and
6 residential providers. We know that a strong
7 infrastructure of community-based services decreases
8 the need for inpatient beds, but we should be
9 realists and realize we're not going in that
10 direction; instead, the cuts to services that we've
11 seen in Illinois are contributing to a trend of
12 increasing inpatient need.

13 With the recent reductions in State-operated
14 facilities, coupled with the effects of the
15 Affordable Care Act and the advent of the new
16 Medicaid MCOs shifting the population to more
17 private sector providers, we're seeing a rise in
18 need. Preceding this, overall since 1991 we've
19 closed 1481 inpatient psych beds in Illinois. The
20 current trend in need for inpatient beds will only
21 continue to increase in this environment.

22 Lake County in particular has very few
23 options for psychiatric care. There are only two
24 facilities with a total of 75 beds in the entire

1 county, which is far less beds per thousand
2 residents than adequate. As with many areas of
3 Illinois, local treatment is not available, and
4 individuals from Lake County and the larger northern
5 area of Illinois must travel long distances to
6 receive inpatient psychiatric care. Lake County has
7 lost beds with unit closures at several facilities
8 in recent years, and there are also no specialty
9 programs.

10 Another result of the decrease in
11 psychiatric beds over recent years is the common
12 complaint that emergency departments, law
13 enforcement, jails, and prisons are compensating for
14 the lack of availability of care. Our experience at
15 Chicago Behavioral Hospital seems to demonstrate the
16 need. We've gone from a virtually empty hospital a
17 year and a half ago to a census that's been well
18 into the hundreds, and we've often hit capacity in
19 the various programs.

20 Finally, while there's a clear national
21 trend of increase in the number of individuals
22 needing psychiatric care, the National Alliance on
23 Mental Illness estimates that 60 percent of adults
24 and 50 percent of children --

1 MR. ROATE: Two minutes.

2 DR. DE JOSEPH: -- with a serious mental
3 illness are not receiving treatment.

4 CHAIRWOMAN OLSON: Thank you.

5 Next.

6 MS. MURPHY: Good morning. My name is
7 Alfa Murphy, and I'm the practice manager for
8 Associates in Behavioral Science, a psychiatric
9 practice.

10 I should note I've been told that our letter
11 of support was not accepted because it was signed by
12 me rather than one of our physicians. We projected
13 in that letter that we would refer approximately --
14 and this is only a number of the admissions that we
15 have been able to -- for patients that we are unable
16 to treat on our current basis -- 35 patients per
17 month to Northbrook Behavioral Hospital who are from
18 the zip codes in the Northbrook catchment area, for
19 inpatient treatment.

20 We have been providing care to our patients
21 for over 27 years. We are well aware of the need
22 for more psychiatric beds and the need for
23 Northbrook Behavioral Hospital in the Lake County
24 area.

1 Emergency rooms usually call upon us to
2 accept patients for psychiatric care. Many times we
3 are just not able to treat these patients as all
4 beds are filled, leaving our patients in these
5 emergency departments waiting for hours and
6 sometimes days until discharges occur of the few
7 available hospitals.

8 As a professional in the mental health
9 field, we ask you to grant Northbrook Behavioral
10 Hospital a CON to operate and provide the care many
11 patients need. The care these patients need is
12 urgent. Mental illness is sometimes pushed to the
13 side of many of the social issues we face. I am
14 here to tell you that mental illness has no
15 boundaries, does not know social status, and it is
16 the cause of many suicides in patients of all ages.
17 Many of these illnesses can be treated rapidly, but
18 we need the resources and we need these hospital
19 beds.

20 Thank you so much for listening.

21 CHAIRWOMAN OLSON: Thank you.

22 Next.

23 MS. WERESZCZYNSKA: Hello. My name is
24 Kasia Wereszczynska, and over the last eight years

1 I have provided clinical mental health counseling
2 and crisis intervention to a culturally diverse
3 population serving the South Side of Chicago and the
4 North Shore area. I also have a history of working
5 in various settings, including the mental health
6 court system within the Cook County Jail, hospital
7 emergency rooms, community mental health agencies,
8 and both inpatient and outpatient psychiatric
9 hospitals.

10 Throughout this time I have had the vast
11 experience working with many helping professionals,
12 institutions, and agencies. What I have come to
13 notice, though, is that, despite everything
14 currently in place -- the people, the buildings, the
15 resources, the money -- or lack thereof -- the State
16 of Illinois continually struggles to provide the
17 type of care when and where necessary to our
18 patients.

19 As a first responder, I have entered into
20 unspeakable situations where I have only had moments
21 to make an informed decision that may mean the
22 difference between the patient receiving optimal
23 services or those that are anything but.

24 Due to hospitals being over capacity, there

1 have been many instances where patients with
2 psychosis were forced to wait on a bed for inpatient
3 or those with addictions were unable to get
4 treatment when experiencing severe withdrawal or in
5 need of detox.

6 There are other instances where, upon
7 arrival to the emergency rooms, clerical errors have
8 occurred. This took a toll on patients' already
9 dire situations from terrible to worse.

10 Perhaps even more frustrating was the time
11 when I called over 31 Chicagoland hospitals to place
12 an adolescent child that was suicidal but had to
13 resolve with sending her to the Pavilion in
14 Champaign, which is three hours away. Clearly,
15 something is not right with this situation.

16 I support the Northbrook Behavioral health
17 project. Every patient deserves respect,
18 compassion, integrity, and access to services. As
19 such, this fine organization has the people, talent,
20 resources, and so on to provide our patients with
21 just that. Furthermore, it adds another location
22 where patients --

23 MR. ROATE: Two minutes.

24 MS. WERESZCZYNSKA: -- in the North Shore

1 suburbs may be served.

2 Thank you.

3 CHAIRWOMAN OLSON: Thank you.

4 Next.

5 DR. RANGANATHAN: Good morning, everyone.

6 My name is Dr. Ranganathan, Thodur Ranganathan.

7 I've been a practicing psychiatrist for about

8 28 years.

9 I think you've heard a lot of stuff that
10 I probably wanted to share. In the interest of
11 time, I'll say this: I have been involved in many
12 aspects of what some of the other speakers have
13 shared.

14 I've been in the system, the community
15 system. I worked as a community psychiatrist for
16 almost 24 years, the first 24 years of my career.
17 The last four years, unfortunately, that's been my
18 passion, but there's no more centers, especially in
19 inner cities, south side of Chicago, where I used
20 to get involved significantly. About four to
21 five agencies that gather significant patients and
22 families with illnesses disappeared.

23 Emergency rooms is the other thing. I've
24 developed an emergency psych service of an inner-

1 city hospital many years ago in conjunction with the
2 State of Illinois to offer some meaningful,
3 compassionate care, make sure the patients don't
4 just wait in the ER. ER physicians typically don't
5 have the expertise for other patients, and they
6 don't want to be bothered with psych emergencies.

7 What I see now is the shortage -- and,
8 again, when you look at numbers -- I kind of briefly
9 looked at some numbers as far as hospitals and beds.
10 My consensus is that there's about 35-, 36,000 total
11 hospital beds in the state of Illinois, 200-plus
12 hospitals. There's only about -- what? -- not even
13 10 percent of psychiatric beds, number one.

14 The other thing is some of the community
15 hospitals that do offer psychiatric beds, I think
16 they're walking away from it typically because they
17 don't want to be managing difficult patients, acute
18 patients for several reasons, which I probably don't
19 have the time to go into.

20 I think -- I've been in a couple of
21 specialty hospitals. I recently joined Chicago
22 Behavioral a few months ago. I've been part of
23 another freestanding psych hospital, and these are
24 the hospitals, I think, that would be able to offer

1 the specialized care that our population needs,
2 patients with significant mental illnesses. They
3 need special things. You've heard about geriatric
4 care; you've heard about the young adults, the child
5 and adolescents, probably other specialty care, the
6 veterans program. Women's mental health is
7 absolutely critical and important.

8 I think some of the regular community
9 hospitals probably don't have --

10 MR. ROATE: Two minutes.

11 DR. RANGANATHAN: -- the resources, and
12 I would appreciate if you would consider the
13 approval.

14 Thank you for the time.

15 CHAIRWOMAN OLSON: Thank you.

16 Next, Jeannie.

17 MS. MITCHELL: The next five will also be
18 speaking on Project No. 16-011, Northbrook
19 Behavioral Hospital.

20 And they are Nancy Carstedt, Colonel David
21 Sutherland, Donna Wattenberg, Renée Shopp, and
22 Ellen Brown.

23 Please don't forget to sign in, but you do
24 not have to sign in before you begin speaking. And

1 if you have written comments, if you can please hand
2 them over to Mr. Mike Constantino.

3 MS. CARSTEDT: My name is Nancy Carstedt.

4 I am the executive director of the North Shore --
5 Cook County North Shore affiliate of the National
6 Alliance on Mental Illness, NAMI.

7 Northbrook is one of the 17 communities in
8 our catchment area, and I'm here this morning to
9 strongly support the proposed 100-bed psychiatric
10 hospital in Northbrook.

11 Recently I accompanied my disabled son to
12 the emergency room at Evanston Hospital. While we
13 were there, there were three security guards keeping
14 watch over three patients who were experiencing
15 acute symptoms of mental illness and were being held
16 in the emergency room pending transfer to a
17 psychiatric facility. One patient had been there
18 over 48 hours, another nearly 36 hours, and the
19 third over 6 hours. Their transfer was contingent
20 on finding an available bed in a psychiatric
21 facility.

22 During the time that my son and I were
23 there, the patient who had been there for over
24 48 hours was transferred to a psychiatric facility

1 in the south suburbs of Chicago, nearly 40 miles
2 away, making support of family members difficult, if
3 not impossible.

4 Almost any day at any time, this is a common
5 occurrence in the emergency rooms of the several
6 hospitals in the northern suburbs of Chicago. There
7 are simply too few psychiatric beds to meet the need
8 for such beds.

9 In any given year, one in five adults will
10 experience a serious mental health condition, many
11 requiring hospitalization. Northbrook Behavioral
12 Hospital would provide a much-needed option for the
13 dozens upon dozens of patients needing immediate
14 psychiatric services that are now being warehoused
15 in local emergency rooms awaiting bed availability.
16 During the past few years, we've seen
17 two psychiatric units in our area in local hospitals
18 close, only exacerbating the problem.

19 Mental illness is a treatable illness, much
20 like cancer or diabetes. As with most illnesses,
21 the more prompt the treatment, the more likely a
22 successful outcome. While waiting in ERs, the
23 patient receives no treatment and valuable time is
24 lost. The voices become louder and more persistent

1 in the schizophrenic's head.

2 MR. ROATE: Two minutes.

3 MS. CARSTEDT: I urge you to support the
4 Northbrook Behavioral Hospital project as a means of
5 providing quality care in the northern suburbs.

6 Thank you.

7 CHAIRWOMAN OLSON: Thank you.

8 COLONEL SUTHERLAND: My name is retired Army
9 Colonel David Sutherland, and I'm a vocal advocate
10 for veterans and military families across the
11 nation, and I'm here in support of Northbrook
12 Hospital.

13 The needs of our veterans and military
14 families are evolving. They're not disappearing.
15 And it's happening at a time when the American
16 people are forgetting about the wars, and we cannot
17 allow them to forget about the veterans and military
18 families.

19 US HealthVest is changing the narrative
20 that, when it comes to Illinois veterans and their
21 families, specifically they don't have to be
22 isolated to government programs that are not readily
23 available in their communities. HealthVest is doing
24 this through a culture driven by shared values with

1 those that have served, an understanding of loyalty,
2 respect, personal courage, and honor.

3 I have watched US HealthVest and facilities
4 they've been associated with in communities across
5 the country since 2010 after I returned from
6 commanding 12,000 US service members and
7 45,000 coalition forces in -- during surge
8 operations in Iraq, and I recognize that their
9 outreach and their shared vision is one that will
10 not tolerate another generation of homeless veterans
11 or tolerate the status quo when it comes to the
12 22 veterans a day that are committing suicide, the
13 shortage of services and the fact that Illinois
14 ranks No. 10 of the most populated states for
15 veterans with more than 721,000 veterans living in
16 your communities yet ranks 41st in services as a
17 state, and some of these services include mental
18 health.

19 The shortage in services is caused by an
20 epidemic of disconnection between the military and
21 civil society. It's an epidemic that drives a lack
22 of or shortage of services in terms of health care.

23 Tom Young was an Army veteran living in the
24 Chicago area who sought the VA help in dealing with

1 suicidal thoughts. Tom called the VA hotline --

2 MR. ROATE: Two minutes.

3 COLONEL SUTHERLAND: -- seeking treatment,
4 and the next day he committed suicide.

5 I urge you to support Northbrook.

6 CHAIRWOMAN OLSON: Thank you.

7 And thank you for your service.

8 MS. ELLEN BROWN: Hi. My name is
9 Ellen Brown. I'm a licensed professional counselor
10 with Mental Health Solutions --

11 CHAIRWOMAN OLSON: You're going to need to
12 pull that much closer.

13 MS. ELLEN BROWN: Oh. Sorry.

14 We're a therapy and counseling practice in
15 Barrington and Mundelein. I'm delighted to be here
16 today to represent our practice in support of the
17 establishment of Northbrook Behavioral Hospital.
18 I'm here to testify directly to the Board because my
19 letter sent in support of Northbrook Behavioral
20 Hospital was not recognized when the Board reviewed
21 the letters.

22 During my time in practice, I've already had
23 numerous experiences where clients have less than
24 adequate access to mental health resources. I've

1 had clients in crisis turned away from mental health
2 care due to lack of available resources. I've had
3 clients wait hours in emergency rooms before they
4 could be seen, only to be told there were no
5 psychiatric beds available.

6 Just waiting for hours in an emergency room
7 can be traumatizing to any person, let alone someone
8 suffering from anxiety, depression, or other mental
9 health conditions. The wait time and traumatic
10 experience is compounded by spending time in the
11 general emergency room full of other patients with
12 heart attacks and other serious mental -- medical
13 problems.

14 An emergency room and hospital dedicated to
15 mental health conditions would alleviate many of
16 these issues. It's obviously frustrating for our
17 clients, and as a counseling community it is
18 extremely frustrating that we cannot provide the
19 optimal care that our clients require and deserve.
20 This is why it's so exciting to hear of the
21 potential opening of the Northbrook Behavioral
22 Hospital.

23 This would open up so much more access and
24 timely access in an area that is so sorely lacking.

1 Not only will Northbrook Behavioral Hospital improve
2 and expand upon access for mental health care but
3 they will offer care for a wide spectrum of client
4 types from adolescents to geriatric, women's focus
5 groups, and even military clients.

6 It is my sincere hope that you will consider
7 these facts and vote in favor of the establishment
8 of the Northbrook Behavioral Hospital, help the
9 community at large, and our counseling communities
10 in particular will benefit from this.

11 Thank you.

12 CHAIRWOMAN OLSON: Thank you.

13 Next.

14 MS. SHOPP: My name Renée Shopp. I'm a
15 psychiatric nurse and practice manager for Mathers
16 Clinic. My letter was not previously recognized by
17 the Board.

18 Mathers Clinic is a mental health and
19 substance abuse practice in Rockford, Woodstock,
20 Crystal Lake, Elgin, and Fox Lake. We provide
21 psychiatric services also to 15 assisted-living and
22 nursing homes.

23 Our patients have experienced ongoing delays
24 in accessing inpatient psychiatric care, mainly due

1 to the lack of beds. There have been multiple times
2 when patients have had delayed access to care, and
3 an average admission can take me five to six hours
4 looking for a facility. And if I'm looking for a
5 client who needs a geriatric psychiatric facility,
6 that might take me two to three days.

7 We currently have clients coming from
8 Northbrook, Prospect Heights, Wheeling, Barrington
9 Hills, Fox Lake, Grayslake, Gurnee, Highland Park,
10 Ingleside, Island Lake, Lake Bluff, Libertyville,
11 Mundelein, Vernon Hills, North Chicago, Round Lake,
12 Waukegan, Buffalo Grove, and Zion and Niles.

13 This year our community mental health center
14 closed in McHenry, and Mathers Clinic is now a
15 community mental health center. We also opened an
16 immediate care service so, instead of waiting two to
17 six months for psychiatric care, clients can receive
18 care the same day.

19 In order to continue providing the services,
20 we need a place to refer, and we would really
21 appreciate your consideration of the Northbrook
22 Behavioral Hospital.

23 CHAIRWOMAN OLSON: Thank you.

24 Next.

1 MS. WATTENBERG: Good morning, Chairwoman
2 and Board members. My name is Donna Wattenberg.
3 I am past president of NAMI -- which stands for
4 National Alliance of Mental Illness -- northwest
5 suburban. My duties have been varied and many with
6 the affiliate. I currently answer, for the last
7 two years, our helpline, which extends into the
8 northwest area.

9 I can, you know, read a list. Just to keep
10 it short, we just celebrated -- NAMI northwest
11 suburban -- our 30th anniversary. We're a
12 well-established community. We are volunteer based.
13 We are knowledgeable laypeople. We advocate,
14 educate, and have support groups.

15 We, being NAMI northwest suburban, our board
16 members, and my fellow community members all support
17 the Northbrook Behavioral Hospital.

18 Please take into consideration that this
19 hospital is well needed. There are consumers of
20 mental health services in our local area that have
21 been refused -- refused, I said -- admittance. Why?
22 Because there's not enough beds.

23 These are cousins, sisters, brothers,
24 mothers, fathers, uncles, aunts, et cetera, people

1 like you and I being refused because there are no
2 beds available. What's available is out of reach of
3 many family members and loved ones', you know,
4 traveling distance.

5 When the consumers of mental health services
6 come through the ER, they are in need of immediate
7 services. They are in need of immediate services.
8 That's why they're in the ER room.

9 MR. ROATE: Two minutes.

10 MS. WATTENBERG: I wish to let you know that
11 our community does need this hospital. Thank you
12 kindly for your time.

13 CHAIRWOMAN OLSON: Thank you.

14 Next, Jeannie.

15 MS. MITCHELL: The next two will be speaking
16 on Project 16-012, Transitional Care of Lake County.
17 Please come up. Aaron Lawlor and John Lobaito.

18 And the next three will be speaking on
19 Project 15-044, Transformative Health of McHenry,
20 and please come up. Michelle Stuercke, Jennifer L.
21 Bebinger, and Dr. Birinder Marwah.

22 Please sign in. Prior to signing in -- you
23 can begin speaking before you sign in.

24 MR. LAWLOR: Good morning and thank you.

1 I'm Aaron Lawlor. I'm the chairman of the
2 Lake County Board, and it's my honor to be here to
3 support Project No. 16-012, Transitional Care of
4 Lake County, Mundelein, and its establishment of a
5 new 185-bed long-term care facility because it's in
6 the best interests of the citizens of Lake County.

7 Lake County formerly operated Winchester
8 House, which is currently located in Libertyville at
9 1125 North Milwaukee Avenue and is one of the oldest
10 continuously operated facilities in Illinois. In
11 keeping with Lake County's mission, Winchester House
12 provides skilled nursing facility services,
13 intermediate care services, and activities for the
14 physical, mental, social, and recreational needs for
15 the well-being of the elderly citizens of
16 Lake County in a setting that is compassionate,
17 loving, and a place to call home.

18 In order to preserve that mission for years
19 to come, the Lake County Board and staff, as well as
20 a special task force comprised of citizens, health
21 care professionals, and board members, evaluated
22 various options to make Winchester House a viable
23 and financially self-sustaining entity in the
24 future. We determined that the best solution for

1 Winchester House was to transition its operation to
2 a private company.

3 After an exhaustive and detailed selection
4 process, the Lake Board chose Transitional Care of
5 Lake County to lease and operate Winchester House
6 with the goal of eventually to replace it with a new
7 facility to provide continuing care to Winchester
8 House's residents, decrease the taxpayers' financial
9 obligations, and cease doing business in the nursing
10 home industry.

11 As a part of the multiyear project,
12 Transitional Care of Lake County applied for and
13 received a new license, continued participating
14 in --

15 MR. ROATE: Two minutes.

16 MR. LAWLOR: We ask for your support.

17 Thank you.

18 CHAIRWOMAN OLSON: Thank you very much.

19 Next.

20 MR. LOBAITO: Good morning, Madam

21 Chairwoman, members of the Board.

22 My name is John Lobaito. I am the Village
23 administrator for the Village of Mundelein, and I am
24 here on behalf of Mayor Lentz and the board of

1 trustees. I'm here to express the Village of
2 Mundelein's support for the Transitional Care of
3 Lake County, Project 16-012.

4 Mundelein is a community of 32,000 people.
5 There are no transitional care or long-term care
6 facilities in the community. On February 22nd the
7 concept plan for the facility was presented to the
8 Mundelein Village Board at a public meeting. The
9 proposal received overwhelming support from the
10 Village Board. There were no negative comments on
11 this project.

12 Since that time Innovative Health has been
13 working closely with Mundelein and has invested more
14 than a million dollars in the project to date.
15 We're on track for approving the project by the
16 year's end.

17 It should also be noted that the petition is
18 for a new facility but, in reality, it is
19 replacement of beds for the Winchester nursing home
20 located in Libertyville adjacent to Mundelein.

21 The demographics of the area: There are
22 more than 82,000 people in Lake County over the age
23 of 65. There are more than 34,000 within 20 minutes
24 of the proposed facility location. Mundelein alone

1 has nearly 4,000 people over the age of 65.

2 So today I urge the Board's approval of the
3 certificate of need that will ensure that there will
4 be access to quality long-term care services for
5 Mundelein and the surrounding area.

6 Thank you.

7 CHAIRWOMAN OLSON: Thank you.

8 Next.

9 DR. MARWAH: Good morning, Madam Chairman
10 and respected members of the Board. Thank you for
11 allowing me this opportunity to speak today before
12 you in support of Transformative Health Care of
13 McHenry.

14 My name is Birinder Marwah. I'm a physician
15 with board certification and training in internal
16 medicine, geriatrics, palliative medicine, and
17 hospice medicine. I have more than 30 years of
18 experience taking care of geriatric patients in the
19 Chicagoland area. Currently I'm chief of geriatrics
20 at Advocate Masonic Medical Center.

21 I am here to encourage you to vote in favor
22 of Project 15-044. I have known the Applicant for
23 this project for six years and can speak to his
24 ability and experience in developing and operating

1 transitional care facilities like THM.

2 Good aesthetics, customer service, and
3 state-of-the-art therapy are, of course, very
4 essential ingredients at a skilled nursing facility;
5 however, due to the increasing medical complexity of
6 residents at these facilities, they need diagnostic
7 and therapeutic medical care that is almost at par
8 with what hospitals provide.

9 The Applicant and I have worked closely for
10 four years in the past to develop and then actually
11 implement such a model of care. This care model
12 included mechanisms for comprehensive transfer of
13 relevant clinical data both on admission and
14 discharge of residents to these facilities,
15 immediate availability of various state-of-the-art
16 diagnostic modalities, sophisticated algorithms to
17 monitor for side effects of medications, goal
18 setting to monitor for progress, and access need for
19 change in an ongoing treatment plan, and this is
20 just a partial list of the unique model of care that
21 both of us had run. Those four years that I worked
22 with him were amongst the most fulfilling time in my
23 professional career.

24 I strongly urge the Board to vote in favor

1 of this innovative project. This community will
2 immensely benefit from this project.

3 Thank you.

4 MR. ROATE: Two minutes.

5 CHAIRWOMAN OLSON: Thank you.

6 Jeannie.

7 MS. MITCHELL: The next five speakers will
8 be speaking on Project 15-044, Transformative Health
9 of McHenry. Please come up. Lynette Rugg,
10 Mark Weldler, Joyce Surdick, Clare Ranalli, and
11 Chool Liyanapatabendi.

12 CHAIRWOMAN OLSON: Anyone can begin.
13 Thank you.

14 MS. RUGG: Good morning. My name is Lynette
15 Rugg, and I'm the licensed administrator at
16 Crossroads Care Center in Woodstock, Illinois.

17 I am here to voice my opposition to
18 Transformative Care of McHenry's application. My
19 opposition is directly related to the concerns that
20 have already been identified by the Board and still
21 have not been answered adequately by the Applicant.

22 They profess that the services they plan to
23 offer will be above and beyond what is currently
24 being provided in our facility; however, we have an

1 in-house dialysis center, skilled therapy, including
2 seven-day-a-week coverage, a designated short-term
3 unit with newly renovated rooms, a private dining
4 room area for this unit, both private and
5 semiprivate rooms, and both private and shared
6 bathrooms.

7 The Applicant has also falsely represented
8 the investments that have been made into the
9 physical plant of our facility by using the data
10 from the annual cost reports that does not include
11 the renovations we are currently doing as well as
12 the rooms that have been redone since the last data
13 has been reported.

14 The Applicant has recently provided the
15 Board with statistical data regarding hospital
16 discharge information that would lead you to believe
17 there have been over 700 referrals made throughout
18 our service area that were denied.

19 I can tell you that with respect to our
20 facility that data is incorrect, inaccurate. Over
21 80 percent of our residents have Medicaid as either
22 a primary or secondary payer source. We do not deny
23 patients. We still struggle to achieve an average
24 occupancy of 75 percent. We do not deny patients.

1 I must stress that our facility has invested
2 a tremendous amount of time and resources into
3 becoming a competitive -- being competitive,
4 being -- becoming competitive in the market to
5 service the short-term population in addition to the
6 already existing long-term care population we have
7 always serviced. Our financial viability relies
8 heavily on maintaining and even growing a larger
9 short-term census in order to balance out the
10 revenue needed to remain financially sound.

11 The proposed facility will divert the
12 cream-of-the-crop residents away from us and
13 imbalance the playing field.

14 MR. ROATE: Two minutes.

15 MS. RUGG: I urge you, as a result of these
16 facts, to deny the Applicant's request.

17 CHAIRWOMAN OLSON: Thank you.

18 Next.

19 MS. SURDICK: Hi. I'm Joyce Surdick and I'm
20 here from Fair Oaks Health Care Center in
21 Crystal Lake in opposition of the Transformative
22 Care project, 15-044.

23 To understand the impact this project will
24 have on the Crystal Lake and surrounding area

1 nursing homes, you have to be aware of all the
2 changes that are occurring in the Medicare program.
3 We are currently participating in the bundled
4 payment program. Basically, this program strives to
5 improve the quality of care, but it also has
6 expectations of much shorter lengths of stay. There
7 are many rehab patients in our building for only
8 5 to 10 days.

9 These are not the only hospital bundles, but
10 Fair Oaks is participating in 12 of their own
11 episode bundles which across the board has
12 expectations for shortened length of stays for
13 56 different DRGs. The days of 25- to 30-day stays
14 are long over. This is also the trend with Medicare
15 Advantage programs and private insurance.

16 If Fair Oaks in our \$4.4 million addition
17 with private rooms and showers and the surrounding
18 homes do not get these short-stay patients, we will
19 not have enough patients to keep our buildings
20 running. It is obvious, with the Centegra
21 Hospitals' backing, the intention is to send the
22 great majority of the rehab patients to the
23 Transformative Care facility right on their own
24 property.

1 We will also be losing potential referrals
2 as the Woodstock Centegra moves the majority of
3 their operation to their new Huntley facility, which
4 already has a brand-new Alden skilled nursing
5 facility in the works.

6 To address the statistics from the Board
7 staff -- the Board report for the predicted need for
8 nursing home beds in McHenry County, it is
9 imperative to realize that the private-pay nursing
10 home patients of 10 years ago are now being cared
11 for at assisted-living facilities which have sprung
12 up at a rather alarming rate. At Fair Oaks our
13 private-pay census averaged a little over 50 percent
14 just five years ago; currently we average about
15 25 percent.

16 There are predictions out in the field that
17 25 percent of the lower-rated homes will end up
18 closing. That number alone tells the story of the
19 lack of need for a new facility in our county. In
20 these changing times it is a fight to just --

21 MR. ROATE: Two minutes.

22 MS. SURDICK: -- just stay viable without
23 the addition of new nursing home beds.

24 CHAIRWOMAN OLSON: Please conclude.

1 MS. SURDICK: Thank you for your
2 consideration.

3 CHAIRWOMAN OLSON: Next.

4 MR. WELDLER: My name is Mark Weldler and
5 I'm here in opposition of Transformative Health of
6 McHenry.

7 I'm here from The Springs at Crystal Lake,
8 which is a 97-bed facility that is accredited by the
9 Joint Commission. We just had our second
10 deficiency-free survey in the last five years. We
11 are a transitional care facility just minutes away
12 from the proposed site.

13 We have an on-site dialysis unit. We have
14 advanced programs to care for short-term
15 rehabilitation, and more complex, higher acuity
16 patients with all of the newest technologies
17 available in laboratory and all other services that
18 are there, imaging on the spot in order to ensure
19 that we get the outcomes to get them home as quick
20 as possible.

21 Our nurse staffing is double the state and
22 national levels. Our therapist staffing is over
23 four times the national and state levels. We're the
24 facility that people go to when they don't want to

1 go to a traditional nursing home.

2 We are now doing what the Applicant says is
3 going to be the future of health care, and our
4 length of stay is shorter in our records today than
5 the Applicant proposes that they will have. We
6 already have that.

7 The Applicant's referrals will be coming
8 from Centegra Hospital. The Applicant states that
9 the average length of stay in their facility will be
10 28 days. Now, in order to meet the target
11 utilization that the Board requires, that will be
12 simple math. They will need 70 percent of the
13 referrals coming out of Centegra Hospital, which is
14 the hospital in our area that we all get referrals
15 from, and that is the overwhelming place where we
16 get them from. We get a little from other places
17 but that's it. This is our hospital and we rely on
18 this hospital for our majority.

19 To say that we are against competition would
20 not be true. We did not oppose the other two
21 faculties that have been approved that are not yet
22 open. That are not open yet nor did the Applicant
23 acknowledge those with their analysis of the market
24 with regards to capital improvement, with regard to

1 services, totally not there.

2 To be clear, this will not be competition.
3 If this is approved, they will get those referrals
4 and we will not. And I say this not from fear but
5 from past experience.

6 The hospital had a financial --

7 MR. ROATE: Two minutes.

8 MR. WELDLER: I ask the Board to please
9 consider the impact this is going to have on us, and
10 the length of stay doesn't make sense and the
11 information that they're presenting. Please.

12 CHAIRWOMAN OLSON: Please conclude.

13 MR. WELDLER: Thank you.

14 CHAIRWOMAN OLSON: Next.

15 MS. RANALLI: Good morning. My name is
16 Clare Ranalli, and I am legal counsel for Florence
17 Crystal Pines, The Springs, Crossroads, and
18 Fair Oaks, who you've heard from here today.

19 I would like to just briefly touch upon a
20 concern I have about the application which relates
21 to the referral letters in support of the project.
22 The Applicant did not comply with the Board's rules,
23 which require that a referral letter state the
24 12-month historical referrals and indicate where the

1 referrals were sent and provide patient-by-zip code
2 origin.

3 The Applicant said that it did not do this
4 because of HIPAA, which, in my opinion, is baloney.
5 All Applicants do it; all Applicants comply with
6 their rules. Providing patient origin by zip code
7 and saying "10 patients went to The Springs or to
8 Crystal Pines" does not violate HIPAA.

9 That is critical information and it should
10 have been provided, and the reason that it was not
11 is it would make it very clear what the dramatic
12 negative impact would be on the area facilities
13 within 30 minutes of the proposed site, two of which
14 provide the exact same services, subacute rehab, and
15 many will -- and those have the same services that
16 the Applicant says will set it apart, availability
17 of dialysis, imaging, lab, et cetera. All of those
18 services are already provided in existing four-star
19 facilities in this service area.

20 Lastly, I just want to conclude by also
21 stating I have an issue with the Applicant's claim
22 that within two years, due to the increase of
23 patients in the age cohort 65 and older, all
24 facilities in the area will be at target

1 utilization.

2 Historically, the facilities within
3 30 minutes -- and "historically" means over the past
4 five years when there's been 10 percent growth in
5 people age 65 or older -- have remained static with
6 respect to their utilization. The numbers simply
7 don't compute for some of the reasons that you've
8 heard here today.

9 And, also, the Applicants did ignore the
10 two facilities that have been approved that are not
11 yet operating and the Manor Care facility which may
12 or may not be approved.

13 MR. ROATE: Two minutes.

14 MS. RANALLI: Thank you. I appreciate your
15 time here today.

16 CHAIRWOMAN OLSON: Thank you.

17 Next.

18 DR. LIYANAPATABENDI: Good morning,
19 everybody. My name is Chool Liyanapatabendi.

20 I'm a practicing physician and practicing in
21 hospitals as well as in nursing homes, including
22 long-term care facilities and transitional care
23 facilities and skilled facilities.

24 I have been in private practice for

1 many years, and I am, as I said, a physician. In
2 addition to that, I'm a medical director in several
3 universities.

4 So I'm here completely in support of
5 Transformation Health of McHenry. I want you to
6 please understand -- and I heard everything what
7 people are being told, and I wanted to be clear
8 about what this facility is.

9 So this is not a skilled facility. This is
10 a transform -- a transitional care facility. So
11 what we hear all about the skilled facility --
12 I will give you a very simple example for you to
13 understand. I'm -- as a physician, what -- my
14 concern about my patients.

15 I'll give you one example of my Patient A,
16 has congestive heart failure and has difficulty in
17 walking and shortness of breath, had a hip fracture
18 and went in the hospital and had a hip replacement.

19 And on the other hand, I have Patient B,
20 same age, do not have complicated medical history,
21 fell on ice, had a hip fracture and hip replacement,
22 and now my decision where I'm going to send these
23 two patients to rehab facility.

24 So my number one patient, A patient with

1 complication, I really want to send this patient to
2 a skilled facility because this patient cannot be
3 able to do part of it in therapy because this
4 patient already has heart failure, has other medical
5 problems. So this patient needs to be clearly
6 watched and clearly be taken care of.

7 But I -- on the other hand, my Patient B,
8 without complicated medical history, this patient do
9 not match into the skilled area. This is the
10 patient that should go into the transitional care
11 because this patient does not need the help --

12 MR. ROATE: Two minutes.

13 DR. LIYANAPATABENDI: -- and this patient
14 can leave early, so I will support Transitional
15 Care.

16 CHAIRWOMAN OLSON: Thank you.

17 DR. LIYANAPATABENDI: Thank you.

18 CHAIRWOMAN OLSON: Next.

19 MS. MITCHELL: The next five will be
20 speaking on Transformative Health of McHenry,
21 Project No. 15-044. Please come up. Amanda Andrews,
22 Ebony Scott, Matthew Thengil, Douglas Martin, and
23 Elizabeth J. Kreplin.

24 If you have your comments written, please

1 hand them to Mike Constantino. Please do not forget
2 to sign in before leaving the table. You do not
3 have to speak in the order in which you are called.
4 Anyone can begin speaking.

5 MS. ANDREWS: Good morning, Madam Chairwoman
6 and respected Board members. Thank you for allowing
7 me the opportunity to speak today in support of
8 Transformative Health of McHenry.

9 My name is Amanda Andrews, and I'm a
10 licensed nursing home administrator for a
11 transitional care facility and had the pleasure of
12 working with the manager of this project for
13 nine years.

14 When asked to speak on the benefits of this
15 project, many thoughts came rushing to my mind. The
16 first and foremost was that this project will create
17 a modern-day inpatient rehabilitation center for the
18 increasing number of baby boomers, something which
19 the current PSA does not have to offer.

20 Characteristically speaking, baby boomers are very
21 particular in their research of products and what
22 they invest in. They do not settle for ordinary.
23 They want new and better.

24 Transformative Health of McHenry will meet

1 all these criteria and more. THM offers a unique
2 environment that will meet the individual needs,
3 allow for choice in their care, and rehabilitate
4 patients as quickly and safely as possible to return
5 home to their lifestyle.

6 Think about yourself or your own family
7 members. If I was assisting my baby boomer parents
8 to look for a facility, I would not choose the
9 traditional long-term care nursing home model, which
10 many associate with the sick, frail, and elderly.
11 I would want my parents among the younger,
12 short-term patients who share the common goal of
13 returning home. This can be done at THM, which
14 offers a hundred percent private suites for a
15 therapeutic recovery, call-to-order meals, state-of-
16 the-art rehabilitation equipment, and modern-day
17 medical equipment. This is truly a modern-day
18 facility for the modern-day patient.

19 From my understanding, many of the opponents
20 of THM are weary of this project because they feel
21 THM will steal their patients and take business away
22 from them. However, the marketplace THM is
23 targeting versus the existing marketplace of
24 current, long-term nursing homes is vastly different.

1 In 2014 750 people went outside of the PSA
2 area to find a facility that could meet their needs
3 for rehabilitation because it didn't exist within
4 the current area. Imagine THM keeping these
5 750 people in McHenry. Jobs would be created,
6 economy of local businesses would be stimulated, and
7 the people of McHenry would stay in McHenry. These
8 are all wins.

9 I strongly --

10 MR. ROATE: Two minutes.

11 MS. ANDREWS: -- encourage the Board to vote
12 in favor of THM.

13 CHAIRWOMAN OLSON: Thank you.

14 Next.

15 MR. MARTIN: My name is Douglas Martin. I'm
16 the director of economic development for the City of
17 McHenry and have worked for the City for nearly
18 15 years.

19 I hold a master's degree in urban planning
20 and policy from the University of Illinois at
21 Chicago, and I'm a credentialed manager from the
22 ICMA and a member of the American Institute of
23 Certified Planners.

24 I am before you to express the City of

1 McHenry's strong support for the Transformative
2 Health Care project. My comments today focus on
3 land use, economic impact, and community benefit.

4 Transformative Health of McHenry provides a
5 much-needed and desired level of care into the
6 existing continuum of care on our communities'
7 911 hospital and health care campus. The location
8 for this project is an approved health care district
9 in the city of McHenry.

10 Projections indicate the total direct,
11 indirect, and induced economic impact of this
12 project during and through construction is
13 \$27.5 million. In addition, the annual operational
14 economic impact is projected to be another
15 \$26.4 million.

16 The project is expected to address more than
17 280 economic indicators for our community and have
18 an aggregated economic impact of \$53.9 million for
19 the first full year of operations alone. The
20 project will generate approximately 200 new jobs
21 during construction and 150 full-time equivalent
22 jobs once the facility is up and operational.

23 Transformative Health of McHenry will
24 provide a unique, specialized, state-of-the-art

1 facility, enhancing the health care services of the
2 city and McHenry County. Aging statistics and
3 projections for our county support the need for
4 transitional projects such as this.

5 In conclusion, Transformative Health of
6 McHenry is consistent with the City of McHenry's
7 land use goals, provides an additional quality of
8 life continuum of care benefit, and necessary
9 services within the City's planned health care
10 district and an aggregated economic benefit of
11 \$53.9 million.

12 On behalf of the City of McHenry, we urge
13 your yes vote for this beneficial and worthwhile
14 health care project. Thank you for bringing these
15 services to our community.

16 CHAIRWOMAN OLSON: Thank you.

17 Next.

18 MR. THENGIL: Good morning, Madam Chairwoman
19 and respected members of the Board. Thank you for
20 allowing me the opportunity to speak before you
21 today and in support of Transformative Health of
22 McHenry.

23 My name is Mat Thengil, and I am the
24 director of therapy services for a transitional care

1 facility. I am an occupational therapist with over
2 14 years of experience. I would like to speak
3 directly on the benefits of this innovative model
4 and how it differs from a skilled nursing facility
5 due to the short-term rehab.

6 Unfortunately, many skilled nursing
7 facilities today often create a loss of independence
8 and instill an institutional feeling with their
9 clientele. This is because they provide primarily
10 long-term care services and then attempt to make
11 short-term rehab patients fit the long-term care
12 patient populations.

13 There is not a lot of choice for these
14 residents when it comes to their food, rooms, and
15 partnership with therapy. A nursing home feels
16 institutional, and people seem to lose their sense
17 of self-worth and feel as though they give up a lot
18 of their privacy and independence once they enter
19 the traditional nursing home. Projects like this
20 one give folks alternative choices that promote
21 recovery from illness, function, and independence.

22 For the last several years, there's been
23 greater scrutiny from CMS on lengths of stay and how
24 reimbursement is provided. New models of

1 reimbursement such as bundled payments were created
2 to increase efficiency and decrease waste. Projects
3 like Transformative Health of McHenry provide those
4 efficiencies and ultimately save the government
5 money.

6 Transitional care facilities like this
7 project have proven to have shorter lengths of stay
8 than the shorter-term rehab of a skilled nursing
9 facility. This allows the patients to return home
10 safely and independently much sooner by taking
11 advantage of seven days a week of therapy, state-of-
12 the-art equipment, multiple sessions of therapy
13 throughout the day, home safety evaluations, and
14 community reintegration tasks.

15 The goal of this program is to not only
16 rehabilitate our patient but to allow these patients
17 a better opportunity to prevent illness and avoid
18 future hospitalizations.

19 I strongly encourage the Board to vote in
20 favor of Transformative Health of McHenry. Patients
21 and the government will benefit. Thank you.

22 CHAIRWOMAN OLSON: Thank you.

23 MS. KREPLIN: Good morning, Chairwoman and
24 respected members of the Board. Thank you for this

1 opportunity to speak in support of Transformative
2 Health Care of McHenry.

3 My name is Elizabeth Kreplin. I'm a
4 lifelong learner and have professional experiences
5 in business and health care. It has been an honor
6 and privilege to provide care as a registered nurse
7 for the last 16 years.

8 My first nursing experiences were in home
9 health, followed by four years in a nursing home
10 from a staff nurse to director of care delivery.
11 The last five years were as director of nursing of a
12 new transitional care facility, hired by an owner/
13 operator of the THM project. I was privileged to
14 work under his vision for patient-centered care with
15 high-acuity patients in a transitional health care
16 setting. We hired nurses with stellar clinical and
17 critical thinking skills dedicated to a culture of
18 respect and individualized patient care, providing
19 ongoing patient assessments and personalized
20 education.

21 We were consistently rated a CMS five-star
22 facility, Joint Commission certified, and provided
23 advanced medical practice protocols and programs as
24 well as state-of-the-art therapy. Continuity of

1 care from admission to discharge resulted in reduced
2 length of stay, reduced 30-day rehospitalization,
3 and enhanced patient satisfaction with optimal
4 function and timely recovery.

5 In my professional opinion and experience,
6 nursing homes with short-term rehab may be an
7 attempt at transitional care. They are not a
8 comprehensive solution. Transitional care is,
9 indeed, transformative, not only as it serves
10 patients but for its innovative impact on the health
11 care industry.

12 I strongly encourage the Board to vote yes
13 in favor of this innovative project, No. 15-044.
14 Thank you.

15 CHAIRWOMAN OLSON: Thank you.

16 Next, Jeannie.

17 MS. MITCHELL: The next five, also speaking
18 on Transformative Health of McHenry, Project
19 No. 15-044, please come up. Bernie Powers,
20 Lisa Ulm, Henry J. Ecker, Mary D. Tichelbaut, and
21 Kimberly Boike.

22 CHAIRWOMAN OLSON: Go ahead.

23 MS. ULM: Good morning. Thank you for
24 allowing me the opportunity to speak before you

1 today and in support of Transformative Health of
2 McHenry.

3 My name is Lisa Ulm. I am a licensed
4 nursing home administrator and have worked in the
5 skilled nursing and transitional care sector for the
6 last 15 years. Over the last six years I have
7 opened four and personally managed and directed the
8 stabilization and daily operations for three
9 transitional care facilities like this project.

10 I would like to speak to my experience
11 regarding the impact projects like this have on a
12 marketplace. Facilities like Transformative Health
13 of McHenry not only fill gaps in the continuum of
14 care, they seem to act as catalysts that spark a
15 positive chain reaction of improved health care
16 services across the market. As other area providers
17 up their game, access improves, surveys gets better,
18 managing return to hospitalizations improves, and
19 capital gets reinvested in aging properties. All
20 this ultimately benefits the patients and their
21 families.

22 Another phenomenon that I have witnessed is
23 that transitional care facilities can actually
24 create a new demand for their services in the

1 market. I think this is due to two primary reasons.
2 One, access improves by decreasing restrictive
3 admissions practices, and, two, patients who may
4 have bypassed a traditional nursing home are willing
5 to admit to a transitional care facility for
6 rehabilitation.

7 In 2011 I opened and operated a short-term
8 care facility with the managers of this project and
9 entered a very established market. Over a six-year
10 period there was not a single facility closure. In
11 my opinion, adding this state-of-the-art facility
12 required the surrounding facilities to improve the
13 quality of their physical plant and overall service,
14 which most assuredly resulted in a better experience
15 for health care consumers in our area regardless of
16 which facility they chose to provide their care.

17 In conclusion, I strongly encourage the
18 Board to vote yes in favor of this much-needed
19 facility for the people of McHenry. Thank you.

20 CHAIRWOMAN OLSON: Thank you.

21 Next.

22 MS. POWERS: Good morning, Madam Chairwoman
23 and respected members of the Board. Thank you for
24 allowing me to have the opportunity to speak before

1 you today in support of Transformative Health Care
2 of McHenry.

3 My name is Bernadette Powers, and I am a
4 director of food services in health care with
5 37 years in management experience. I have lived
6 here in McHenry County for almost 30 years, 26 of
7 those years in the town of McHenry, and I've seen
8 this community grow up from a sleepy little river
9 town to a vibrant community.

10 I'm here to encourage you to vote in favor
11 of Project 15-044 as we need to provide transitional
12 care for short-term patients, especially those under
13 the age of 60.

14 The hospitals in the area understand that,
15 in order to attract people to our community, both
16 patients and high-quality health care providers,
17 they need to compete with those high standards of
18 health care closer to the city. They knew that they
19 needed a state-of-the-art health care facility that
20 could support what people deserve, the same quality
21 of health care they were getting in more affluent
22 areas closer to Chicago.

23 Now we need to do the same for short-term
24 patients in transitional care, as it does not exist

1 at present. I know of a lot of facilities that say
2 that they can take care of younger, short-term
3 patients by putting a few rooms aside or even a
4 hallway designated for this use. But if you are a
5 long-term facility, this is very hard to do, and it
6 requires a different focus to their primary mission.

7 Presently I drive 40 miles, a three-hour
8 round-trip commute to work with a team of
9 professionals that truly understand the meaning of
10 hospital-to-transitional care-to-home model,
11 catering to the needs of patients that require a
12 fast recovery and return to their normal lives as
13 soon as possible. You may think this is crazy to
14 drive this far --

15 MR. ROATE: Two minutes.

16 MS. ULM: -- but I --

17 CHAIRWOMAN OLSON: Please conclude.

18 MS. ULM: -- but I urge you that this is
19 very vital to the community, and I hope you approve
20 it. Thank you.

21 CHAIRWOMAN OLSON: Thank you.

22 Next.

23 MS. TICHELBAUT: Good morning, Madam

24 Chairwoman and members of the Board.

1 CHAIRWOMAN OLSON: Can you pull that closer
2 so we can hear you?

3 Thank you.

4 MS. TICHELBAUT: My name is Mary Drislane-
5 Tichelbaut. Thank you for allowing me to speak
6 before you today. I am here to speak on behalf of
7 McHenry Transformative Health Care facility.

8 On February 3rd, 2016, I broke both of my
9 knees due to a freak accident fall in my own home.
10 After spending three days at Lutheran General
11 Hospital, I was told that my needs would best be met
12 in a short-term rehab facility.

13 The search began for a facility. Of course,
14 not having any need to use so before, the Google
15 search began. I found a facility in Niles,
16 Illinois. Before arriving at my TCF, I was sure
17 that I was not going to like this place because of
18 the stigma of what I thought it was going to be.
19 The website and various reviews were all very
20 positive in regard to this facility, so I figured
21 I would be okay.

22 Wow, was I wrong about my initial feeling.
23 Upon my arrival I was made to feel like I was a
24 guest in a hotel, not a hospital patient. The staff

1 was very welcoming, kind, and generous to me.
2 I felt like I was a human being, not just a number.
3 I felt loved and treated with kindness and respect.

4 All the staff members knew me by my name
5 whenever they saw me. That was such a personal
6 touch to me. The private rooms with large flat-
7 screen televisions, table and chairs, mini fridge,
8 and loveseat all made my room seem like a hotel
9 room, not a hospital room.

10 I received the best transitional care
11 treatment through the help of my CNAs and nurses who
12 were always looking out for my safety as well as my
13 comfort.

14 MR. ROATE: Two minutes.

15 MS. TICHELBAUT: At this point I can only
16 say the therapists I had also were very --

17 CHAIRWOMAN OLSON: I need you to conclude.

18 MS. TICHELBAUT: -- conscientious, and
19 I feel the need for a facility like this is much
20 needed in the McHenry area.

21 CHAIRWOMAN OLSON: Thank you.

22 MS. BOIKE: Good morning. My name is
23 Kimberly Boike. I'm presenting testimony in
24 opposition to Project 15-044, Transformative Health

1 of McHenry, on behalf of Manor Care Health Services,
2 LLC; HCR Healthcare, LLC; HCR Manor Care, Inc.; and
3 Manor Care Health Services-Libertyville, LLC.

4 On November 13, 2015, the Circuit Court of
5 McHenry County reversed this Board's decision
6 denying Manor Care's proposed project to construct a
7 130-bed skilled nursing facility in McHenry County
8 and issued an order instructing this Board to issue
9 a CON permit for the Manor Care project. This Board
10 has appealed that decision, which appeal is
11 currently pending.

12 Because the planning area bed need in
13 McHenry County should be considered after Manor
14 Care's project approval is finalized, this Board
15 must deny the Transformative Health project.

16 Further, if this Board believes that the
17 negative information supplied by Transformative
18 Health regarding existing providers constitutes a
19 good reason to overlook Transformative Health's
20 inability to comply with the criteria noted in the
21 staff report, then this Board should deny the
22 Transformative Health project, follow the direction
23 of the Circuit Court to approve the Manor Care
24 project, and withdraw its appeal of the Manor Care

1 project.

2 Thank you.

3 CHAIRWOMAN OLSON: Thank you.

4 Next.

5 MS. MITCHELL: The last two individuals will
6 also be speaking on Transformative Health of
7 McHenry, Project No. 15-044. First is Mark --
8 either Jamer or James. The second individual is
9 Larry Banks.

10 MR. JAMES: Good morning. My name is
11 Mark James and I'm the business office manager at
12 Crystal Pines Rehabilitation & Health Care Center.
13 I'm here to oppose the Transformative Care project
14 primarily for -- I want to speak to a couple of
15 issues.

16 First, at the last minute, the Applicant
17 sent in a chart that they presented as CMS
18 information purportedly to show referrals to various
19 facilities that were denied, attempting to claim
20 that facilities deny 50 percent of the referrals.

21 There are a number of problems with this
22 chart. First, the chart is missing two facilities
23 in the area that had substantial admission from this
24 hospital.

1 Second, CMS can only track information on
2 traditional Medicare A-billed patients, which the
3 chart does not include admissions to area providers
4 whose stay in the hospital that was paid for by
5 Medicare Advantage, commercial insurance, Medicaid,
6 or private pay.

7 Third, they show a column representing
8 referrals from the hospital and want you to believe
9 this is CMS data. This is not, as CMS does not
10 track referrals from hospitals, only admission to
11 these. The table/chart is, quite frankly, false and
12 a complete distortion of information.

13 As the business officer manager at Crystal
14 Pines, it's my job to approve people that are
15 referred. We do not deny 48 percent of people who
16 have been sent to us by -- for referrals by
17 Centegra. What happens is a lot of times a
18 patient -- a case manager will send it out to
19 multiple facilities at the same time. That is the
20 only way that they could come up with that kind of
21 information with respect to Crystal Pines. Our
22 referral refusal rate would be somewhere below
23 10 percent.

24 My next point is to address the Applicant's

1 claim that despite taking anywhere from 30 to
2 80 percent -- depending on which of their numbers
3 you use -- of the current referrals from area
4 facilities, it will not matter because within the
5 next year and a half to two years this project and
6 all area facilities will be at target utilization
7 due to population growth in the age cohort --

8 MR. ROATE: Two minutes.

9 MR. JAMES: Thank you for your time.

10 CHAIRWOMAN OLSON: Thank you.

11 Next.

12 MR. BANKS: Hi. My name is Larry Banks, and
13 I'm here in opposition to Project 15-044.

14 I'd like to start by saying there's
15 two facilities that have been approved in the area
16 that are currently going to open, which will already
17 be negatively impacting the facilities.

18 Secondly, it's talked again and again about
19 a transitional care facility. A transitional care
20 facility is a licensed skill nursing facility.
21 That's the only thing that there is. So to say it's
22 not a skilled nursing facility or it's not a
23 trend -- a typical facility -- it is not true.

24 I can give you an example of another

1 facility that is probably a mile from the current
2 proposed site, The Springs at Crystal Lake. There's
3 nothing institutional about that center. It is
4 100 percent transitional care. They only take
5 short-term rehab patients and no long-term care
6 patients. It is a beautiful facility, recently
7 renovated, and has 65 percent occupancy. That is
8 not due to the fact that people aren't choosing it.
9 It's due to the fact that there are not people to
10 fill it.

11 This facility is not going to be built in a
12 medically underserved area. There are more than
13 enough beds in the service area. If they really are
14 going to address a need, why are they building a
15 limited-access facility in the middle of an area
16 that is already a densely bedded area?

17 They say that we are going to steal --
18 we're -- the facilities in the area feel that
19 they're going to steal patients. It's not that
20 there's patients to be stolen. The numbers that
21 mark this at 750 patients is not true. It is not
22 the CMS information, it shouldn't be represented as
23 CMS information, and I think it's terrible that they
24 would have a misrepresentation like that in their

1 application.

2 There are many modern-day facilities in the
3 area. You heard that there's been millions of
4 dollars in the last year --

5 MR. ROATE: Two minutes.

6 MR. BANKS: Thank you.

7 CHAIRWOMAN OLSON: Please conclude.

8 MS. MITCHELL: There are no additional
9 speakers.

10 CHAIRWOMAN OLSON: Is there anybody else
11 that did not have an opportunity to speak who was
12 signed in?

13 (No response.)

14 CHAIRWOMAN OLSON: Okay. It is now 12:15.
15 We'll break for lunch until one o'clock.

16 Please be back at one o'clock.

17 (A recess was taken from 12:15 p.m. to
18 1:03 p.m.)

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1 CHAIRWOMAN OLSON: We'll return to session.
2 The next item is Item No. 5, items approved
3 by the Chairwoman.
4 Mr. Constantino.
5 MR. CONSTANTINO: Thank you, Madam Chairwoman.
6 The following have been approved by the
7 Chair: Permit Renewal 14-026, Permit Renewal 14-041,
8 Permit Renewal 13-013, permit renewal for 15-058,
9 permit renewal for 15-060, and permit renewal for
10 14-022.

11 Thank you, Madam Chairwoman.

12 CHAIRWOMAN OLSON: Thank you, Mike.

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1 CHAIRWOMAN OLSON: The next item of business
2 is items for State Board action.

3 First, we have one permit renewal request,
4 Project 10-065, Park Pointe South Elgin Healthcare &
5 Rehabilitation.

6 May I have a motion to -- may I have a
7 motion to approve a permit renewal for
8 Project 10-065, Park Pointe South Elgin Healthcare &
9 Rehabilitation, for a 24-month permit renewal?

10 MEMBER GALASSIE: So moved.

11 MEMBER SEWELL: Second.

12 CHAIRWOMAN OLSON: The Applicant will come
13 to the table.

14 Please be sworn in by the court reporter.

15 (One witness sworn.)

16 THE COURT REPORTER: Thank you.

17 CHAIRWOMAN OLSON: Mr. Constantino, your
18 report.

19 MR. CONSTANTINO: Thank you, Madam Chairwoman.

20 Park Pointe South Elgin Healthcare & Rehab
21 Center is requesting the third permit renewal for
22 this project.

23 The renewal is for 24 months, until May of
24 2018. The original project was approved for

1 120 beds at an approximate cost of \$21.7 million.

2 Thank you, Madam Chairwoman.

3 CHAIRWOMAN OLSON: Thank you.

4 Questions by Board members?

5 MEMBER GREIMAN: Yeah.

6 What -- what changes are being made to -- so
7 that you can be -- with your dollars -- the 2010 and
8 2016 must have a significant economic difference.
9 Doesn't it?

10 MR. CONSTANTINO: When it was originally
11 approved, Judge, it was -- they were going to use
12 financing from the County --

13 MEMBER GREIMAN: Yeah.

14 MR. CONSTANTINO: -- bonds from the County,
15 and that fell through. Subsequently they've come
16 forward and found additional financing, and that's
17 been the biggest cause of the delay.

18 MEMBER GREIMAN: I understand. I appreciate
19 that. That was in your report.

20 My question is, when was the loss -- the
21 extra costs.

22 MR. CONSTANTINO: Oh, there's been no extra
23 costs.

24 MEMBER GREIMAN: You mean they're

1 charging -- they're working on the 2010 numbers?

2 MR. CONSTANTINO: That's correct. As they
3 reported to us, yes.

4 MEMBER GREIMAN: Is that right?

5 MS. WESTERKAMP: That is correct. The
6 original financing was through bonds, and bond
7 financing can be very expensive. And we are now
8 using private funds and private financing so the
9 cost --

10 MEMBER GREIMAN: I understand that. But the
11 contractors, the subcontractors that are going to be
12 working on this thing, are they charging the 2010 --

13 MS. WESTERKAMP: Actually, they are working
14 off the 2010 budget and they've accepted that.

15 MEMBER GREIMAN: They are? Okay.

16 That's what I wanted to know. I wanted to
17 be sure.

18 CHAIRWOMAN OLSON: So I have a question.

19 So at this point no dirt has been moved?

20 MS. WESTERKAMP: No dirt has been moved. We
21 are ready to break ground on August 1st. We wanted
22 to actually -- because of the recoveries on bonds,
23 not being able to obtain the letter of credit with
24 the State that expired, we went to private

1 financing, and we didn't want to break ground until
2 we had all the private financing funds actually
3 secured in our account. We didn't want to start a
4 project and have to be in the position that we were
5 still trying to raise funds.

6 CHAIRWOMAN OLSON: I understand. But
7 I guess my concern is partially that these beds have
8 now been taken out of the bed count. By the time
9 you open, it will be for eight years that the beds
10 have been tied up with all of the delays.

11 Michael, the project was originally approved
12 in 2010?

13 MR. CONSTANTINO: That's correct.

14 CHAIRWOMAN OLSON: And the most recent
15 completion date is 2018; right?

16 MR. CONSTANTINO: They're requesting a
17 completion date of May 2018, that's correct.

18 CHAIRWOMAN OLSON: So eight years that beds
19 have been out of the inventory.

20 MR. CONSTANTINO: That's correct.

21 CHAIRWOMAN OLSON: And not one shovel of
22 dirt has been moved?

23 MR. CONSTANTINO: That is correct.

24 CHAIRWOMAN OLSON: Can you explain exactly

1 what the financing is now?

2 MS. WESTERKAMP: The financing is secured
3 through DB5 investors which are private investors.
4 These are foreign investors who bring funds to the
5 United States through various types of banks and
6 whatnot.

7 And the benefit of having those investors is
8 that this is -- this is basically an interest-free
9 financing, so the cost of the project remained very
10 low and no monies are paid for accrued interest. No
11 monies are paid for -- profits aren't distributed
12 until after the project is stabilized.

13 CHAIRWOMAN OLSON: And what is your level of
14 confidence that you will meet this May of 2018
15 completion date?

16 MS. WESTERKAMP: We are ready to break
17 ground August 1st. We have our architecture
18 plans -- everything is in place. When we talk about
19 shovel ready -- I know that's a term that's thrown
20 around all the time. Everything's shovel ready. We
21 are -- the land developer is actually ready to put the
22 shovel in the ground. And he would have done it a
23 month ago, but we've been waiting to get the approval.

24 CHAIRWOMAN OLSON: So you're 50 percent

1 confident? 75 percent?

2 MS. WESTERKAMP: I am a hundred percent
3 confident that we'll be ready by May of '18.

4 CHAIRWOMAN OLSON: Other questions?

5 (No response.)

6 CHAIRWOMAN OLSON: Seeing none, I'll ask for
7 a roll call vote.

8 MR. ROATE: Thank you, Madam Chair.

9 Motion made by Mr. Galassie; seconded by
10 Mr. Sewell.

11 Mr. Galassie.

12 MEMBER GALASSIE: Yes.

13 MR. ROATE: Thank you.

14 Justice Greiman.

15 MEMBER GREIMAN: Yes.

16 MR. ROATE: Thank you.

17 MEMBER GREIMAN: I hope this is the last
18 time we'll vote on this.

19 MR. ROATE: Mr. Johnson.

20 MEMBER JOHNSON: Yes. In -- echoing Justice
21 Greiman, I hope this is the last time we hear this.

22 MR. ROATE: Thank you.

23 Mr. McGlasson.

24 MEMBER MC GLASSON: Yes.

1 MR. ROATE: Thank you.

2 Mr. Sewell.

3 MEMBER SEWELL: Yes.

4 MR. ROATE: Thank you.

5 Madam Chair.

6 CHAIRWOMAN OLSON: I'm actually going to
7 vote no.

8 I don't see this being done in May of 2018,
9 and I don't like the fact that these beds have been
10 tied up. It will be over eight years by the time we
11 get things done -- I'm going to guess close to
12 nine years -- so I vote no.

13 MR. ROATE: Thank you, Madam Chair.

14 That's 5 votes in the affirmative; 1 vote in
15 the negative.

16 CHAIRWOMAN OLSON: The motion passes.

17 Good luck.

18 MS. WESTERKAMP: Thank you very much.

19 THE COURT REPORTER: Excuse me. Could you
20 give me your name, please, and spell it.

21 MS. WESTERKAMP: Sure. Janet Westerkamp,
22 W-e-s-t-e-r-k-a-m-p.

23 THE COURT REPORTER: Thank you.

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CHAIRWOMAN OLSON: Next item of business is
extension requests and there are none.

Next is exemption requests and we have none.

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1 CHAIRWOMAN OLSON: We have one alteration
2 request, Project 11-104, McAllister Nursing &
3 Rehabilitation.

4 May I have a motion to approve
5 Project 11-014 -- 104, I'm sorry -- McAllister
6 Nursing & Rehabilitation, to increase the overall
7 project cost by \$3,926.

8 MEMBER JOHNSON: So moved.

9 MEMBER GALASSIE: Second.

10 CHAIRWOMAN OLSON: Mr. Constantino, your
11 report.

12 MR. CONSTANTINO: Thank you, Madam Chairwoman.

13 This is the second alteration for McAllister
14 Nursing & Rehab, LLC. This project was originally
15 approved as a replacement facility for a 111-bed
16 skilled nursing facility with a 200-bed replacement
17 facility at a cost of approximately \$24.9 million.

18 The first alteration increased the gross
19 square footage by 4.3 percent for about 4500 gross
20 square foot. There was no additional cost at that
21 time. And then the second alteration is, like the
22 Chair said, to increase the cost by about \$3926.

23 Thank you, Madam Chairwoman.

24 CHAIRWOMAN OLSON: Thank you.

1 Do you have any comments?

2 MR. KNIERY: I'll open it up to the Board.

3 CHAIRWOMAN OLSON: Any questions?

4 (No response.)

5 CHAIRWOMAN OLSON: Seeing none, I'll ask for
6 a roll call vote.

7 MR. ROATE: Thank you, Madam Chair.

8 Motion made by Mr. Johnson; seconded by
9 Mr. Galassie.

10 Mr. Galassie.

11 MEMBER GALASSIE: Aye.

12 MR. ROATE: Mr. Johnson.

13 MEMBER JOHNSON: Yes.

14 MR. ROATE: Mr. McGlasson.

15 MEMBER MC GLASSON: Yes.

16 MR. ROATE: Mr. Sewell.

17 MEMBER SEWELL: Yes, same.

18 MR. ROATE: Madam Chair.

19 CHAIRWOMAN OLSON: Yes, based on the above
20 statements in the staff report.

21 MR. ROATE: Justice Greiman.

22 MEMBER GREIMAN: Yeah, I'll vote aye.

23 MR. ROATE: Sorry about that, sir.

24 MEMBER GREIMAN: All right.

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

CHAIRWOMAN OLSON: The motion passes.
Congratulations.

MR. KNIERY: Thank you.

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CHAIRWOMAN OLSON: There are no declaratory
rulings or other business.

There is nothing under Health Care Worker
Self-Referral Act and nothing under status report on
conditional/contingent permits, which brings us to
applications subsequent to initial review.

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1 CHAIRWOMAN OLSON: Project 16-015, DaVita
2 Forest City.

3 May I have a project -- may I have a motion
4 to approve Project 16-015, DaVita Forest City
5 Dialysis, to establish a 12-station ESRD facility.

6 MEMBER SEWELL: So moved.

7 MEMBER MC GLASSON: Second.

8 CHAIRWOMAN OLSON: Thank you.

9 Mr. Constantino, your report.

10 MR. CONSTANTINO: Thank you, Madam Chairwoman.

11 The Applicants are proposing to establish a
12 12-station ESRD facility in Rockford, Illinois. The
13 cost of the project is approximately \$3.1 million,
14 and the completion date is June 30th, 2018.

15 There was no public hearing, no opposition
16 letters received, and there were no findings.

17 Thank you, Madam Chairwoman.

18 CHAIRWOMAN OLSON: Thank you.

19 The Applicant -- or the people at the table
20 will be sworn. Sorry.

21 THE COURT REPORTER: Raise your right hands,
22 please.

23 (Four witnesses sworn.)

24 THE COURT REPORTER: Thank you. And please

1 print your names.

2 CHAIRWOMAN OLSON: Do you have comments for
3 the Board? No opposition, no findings. It's up
4 to you.

5 MR. SHEETS: No, we don't have any comments.
6 We would take questions.

7 I have with me Annie Hike, who's the DaVita
8 regional operations director for the Rockford area,
9 and then Mr. Tinknell, who I think you know;
10 Anne Cooper from my office.

11 CHAIRWOMAN OLSON: Questions from Board
12 members?

13 MEMBER GALASSIE: No.

14 CHAIRWOMAN OLSON: This is my stomping
15 grounds here, so I really applaud where you're
16 putting this facility because you guys are way out
17 on the west side, and that's where I know services
18 are desperately needed. So I think that's awesome.

19 Roll call vote, please.

20 MEMBER GREIMAN: I have a question.

21 CHAIRWOMAN OLSON: Oh, I'm sorry.

22 MEMBER GREIMAN: I have a question of the
23 staff.

24 CHAIRWOMAN OLSON: Sorry, Justice.

1 MEMBER GREIMAN: When you figure out the
2 number of the activities in the district, one of our
3 districts, it says pending a -- you've given rights
4 to build, do you count that in your numbers as if it
5 was finished?

6 MR. CONSTANTINO: Are you talking about
7 projects approved, that have been approved and not
8 yet operational?

9 MEMBER GREIMAN: Yeah.

10 MR. CONSTANTINO: Yeah, it's included in the
11 station need calculation. Once you approve it,
12 they're immediately taken out of the need.

13 MEMBER GREIMAN: I see. They are? Because
14 I see that DaVita has a number of pending issues,
15 and I wonder if -- how much that changes the
16 establishment of it.

17 If you look at page 4 of the staff report,
18 you see about 10, 12 pending projects.

19 MR. CONSTANTINO: That's correct.

20 MEMBER GREIMAN: That seems to be a lot of
21 projects. How come you've not finished with them?
22 Why is it taking so long to finish these projects?

23 Not you.

24 You.

1 MR. CONSTANTINO: Thank you, Judge.

2 MR. SHEETS: Well, Judge, the way the need
3 is calculated for these types of facilities
4 basically revolves around people that have a certain
5 stage of the renal disease that will progress at
6 some point to where they need dialysis.

7 So in dialysis it's really a planning
8 activity. We're planning two years down the road --
9 18 months to two years down the road -- for where
10 the patients are and where we think the need
11 calculation will be.

12 MEMBER GREIMAN: So -- okay. So when we
13 give you a right -- authority to have a facility,
14 you don't necessarily move on it because you're
15 waiting to see what's going on in the market; is
16 that right?

17 MR. SHEETS: Well, we do move immediately on
18 it, and it takes -- you know, it takes time to get
19 the building. Sometimes it's a new building;
20 sometimes it's a rebuild.

21 MEMBER GREIMAN: I understand but it's -- a
22 real market. You guys -- you and somebody else --
23 own 90 percent of the renal stations in Illinois so
24 you have -- I'm sure you have it down pretty well.

1 MR. SHEETS: We like to think we do, just
2 like McDonald's and Burger King. You never know.

3 MEMBER GREIMAN: Well, I just -- I was just
4 curious about why you delay and so -- okay.

5 Thank you.

6 CHAIRWOMAN OLSON: Other questions or
7 comments?

8 (No response.)

9 CHAIRWOMAN OLSON: Seeing none, I'll ask for
10 a roll call vote, please.

11 MR. ROATE: Thank you, Madam Chair.

12 Motion made by Mr. Sewell; seconded by
13 Mr. McGlasson.

14 Mr. Galassie.

15 MEMBER GALASSIE: Aye.

16 MR. ROATE: Justice Greiman.

17 MEMBER GREIMAN: Aye.

18 MR. ROATE: Mr. Johnson.

19 MEMBER JOHNSON: Yes.

20 MR. ROATE: Mr. McGlasson.

21 MEMBER MC GLASSON: Yes, by virtue of the
22 staff report.

23 MR. ROATE: Thank you.

24 Mr. Sewell.

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MEMBER SEWELL: Yes, for reasons stated.

MR. ROATE: Madam Chair.

CHAIRWOMAN OLSON: Yes, based on the
positive State Board staff report and the no
opposition.

MR. ROATE: 6 votes in the affirmative.

CHAIRWOMAN OLSON: Motion passes.

Good luck.

MR. SHEETS: Thank you.

MR. TINKNELL: Thank you.

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1 CHAIRWOMAN OLSON: Next we have
2 Project 16-017, Griffin Medical Office building.

3 May I have a motion to approve
4 Project 16-017, Griffin Medical Office Building, to
5 construct a medical office building.

6 MEMBER GALASSIE: So moved.

7 CHAIRWOMAN OLSON: A second, please.

8 MEMBER SEWELL: Second.

9 CHAIRWOMAN OLSON: Thank you.

10 Mr. Constantino, your report.

11 MR. CONSTANTINO: Thank you, Madam Chairwoman.

12 The Applicants are proposing to construct a
13 medical office building in Pekin, Illinois. The
14 project cost is approximately \$17.7 million, and the
15 completion date is April 2nd, 2018.

16 There's a mistake on the front page here.
17 That should be 17,671,566 and not 16 thousand --
18 16,671,566. It's in the third line.

19 CHAIRWOMAN OLSON: Thank you, Mr. Constantino.

20 The Applicant will be sworn in.

21 MR. CONSTANTINO: There was no public
22 hearing, no opposition.

23 Thank you, Madam Chairwoman.

24 CHAIRWOMAN OLSON: Sorry. I didn't mean to

1 cut you off there.

2 MR. CONSTANTINO: That's all right.

3 CHAIRWOMAN OLSON: The Applicant will be
4 sworn in.

5 THE COURT REPORTER: Raise your right hands,
6 please.

7 (Three witnesses sworn.)

8 THE COURT REPORTER: Thank you.

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

11 MR. HALL: My name is Steve Hall. I'm the
12 chief financial officer for Park Court Limited and
13 Progressive Health System. I have Ed Parkhurst, our
14 CON consultant, and Marcia Becker, the director of
15 finance, with me.

16 I'd like to thank the staff for their
17 assistance during the application process and for
18 their determination that we meet the criteria for
19 Part 1110 and 1120.

20 I'd like to report that we've had
21 substantial support from the community, the City,
22 and the County Health Board, the chamber of
23 commerce. It's a very well-thought-out project, and
24 we don't have any opposition.

1 So I'm happy to take questions.

2 CHAIRWOMAN OLSON: Thank you.

3 Questions from Board members?

4 (No response.)

5 CHAIRWOMAN OLSON: I just have one question.

6 Mike, this is actually for you.

7 On page 13 of the -- of your State Board
8 staff report -- I love projects with no opposition
9 and no negative findings. Those are the fun ones.

10 But on -- if we say that the construction
11 and contingencies are high compared to our standard,
12 how are we able to -- how can we find that that's
13 not negative? I just want to make sure that's --
14 I mean, I --

15 MR. CONSTANTINO: When I looked at that, it
16 was high on the -- on what they considered to be the
17 clinical portion of the project, but when I compared
18 it to the other approved medical office building
19 projects, it was in the range that we have approved
20 in the past and accepted.

21 And the second reason we didn't have a
22 negative finding on it was because they have
23 financing already in place and they provided us with
24 a signed document.

1 CHAIRWOMAN OLSON: Okay.

2 MR. CONSTANTINO: They're ready to go.

3 CHAIRWOMAN OLSON: Thank you. I appreciate
4 that explanation.

5 Other questions or comments?

6 (No response.)

7 CHAIRWOMAN OLSON: Okay. Seeing none,
8 I would ask for a roll call vote.

9 MR. MORADO: Before you begin, can I just
10 remind the Board members to please make sure you
11 explain your vote as you do?

12 Thank you.

13 MR. ROATE: Thank you.

14 Motion made by Mr. Galassie; seconded by
15 Mr. Sewell.

16 Mr. Galassie.

17 MEMBER GALASSIE: Aye, based on the State
18 findings.

19 MR. ROATE: Thank you.

20 Justice Greiman.

21 MEMBER GREIMAN: Aye.

22 MR. ROATE: Mr. Johnson.

23 MEMBER JOHNSON: Yes, based on the staff
24 report.

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MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on the staff
report.

MR. ROATE: Thank you.

Mr. Sewell.

MEMBER SEWELL: Yes, for reasons stated.

MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: Yes, based on the
positive State Board staff report and no opposition.

MR. ROATE: Thank you.

That's 6 votes in the affirmative.

CHAIRWOMAN OLSON: Motion passes.

Congratulations and good luck.

MR. HALL: Thank you.

MR. PARKHURST: Thank you very much.

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1 CHAIRWOMAN OLSON: Next, we'll move into
2 Project 15-061, Southern Illinois Gastroenterology
3 Endoscopy Center.

4 May I have a motion to approve Project 15-061,
5 Southern Illinois Gastroenterology Endoscopy Center,
6 to establish a single-specialty ASTC.

7 MEMBER SEWELL: So moved.

8 CHAIRWOMAN OLSON: I have a motion by
9 Mr. Sewell. May I have a second.

10 MEMBER GALASSIE: Second.

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

13 MR. CONSTANTINO: Thank you, Madam Chairwoman.

14 The Applicants are proposing the
15 establishment of a limited-specialty ASTC in
16 approximately 3200 gross square feet of leased space
17 at a cost of approximately \$1.7 million in
18 Carbondale, Illinois. The anticipated completion
19 date is December 31st, 2017.

20 There was no public hearing, there was
21 opposition, and we did have findings.

22 I would like to note, though, one comment
23 that was made during the public participation, that
24 to be -- if you do approve this as an ASTC, they

1 cannot have that license without a transfer
2 agreement with a hospital. IDPH --

3 CHAIRWOMAN OLSON: And it's not currently in
4 place?

5 MR. CONSTANTINO: IDPH will not give them a
6 license without that transfer agreement.

7 MEMBER GALASSIE: Explain the transfer
8 agreement.

9 MR. CONSTANTINO: It's a transfer
10 agreement -- if they have problems during the
11 procedures performed at the ASTC -- with the
12 hospital. And there's two hospitals within
13 10 minutes of the proposed site.

14 MEMBER SEWELL: I didn't hear your answer to
15 the Chairman's question.

16 CHAIRWOMAN OLSON: It's not in place.

17 MEMBER SEWELL: Oh, it's not in place.

18 CHAIRWOMAN OLSON: Is that correct? It's
19 not -- there's no transfer agreement?

20 MR. SHEETS: Well, there's no ASTC so there
21 can't be a transfer agreement.

22 CHAIRWOMAN OLSON: So, it's a chicken-or-egg
23 thing?

24 MR. SHEETS: Right.

1 MEMBER GALASSIE: So would we want to amend
2 our motion to having that agreement in place?

3 MR. MORADO: They won't be able to receive
4 the licensing from IDPH without having something
5 like that in place, so it's a function that would
6 happen after they are either granted or denied
7 the CON.

8 CHAIRWOMAN OLSON: Because we've had a lot
9 of ASTCs here before, and I've never -- did they all
10 have transfer agreements?

11 MR. CONSTANTINO: Oh, to get the license
12 they had to have it.

13 CHAIRWOMAN OLSON: No, no, no. I mean
14 before we approved them.

15 MR. CONSTANTINO: No. That's not one of
16 our --

17 CHAIRWOMAN OLSON: So no one has ever
18 had it?

19 MR. CONSTANTINO: Not at the time -- they
20 did not submit a transfer agreement as part of our
21 application for permit. It's not a requirement.

22 But during public comment that issue was
23 raised, and I'm just pointing out that, if you
24 approve this project as an ASTC, they cannot get

1 that license without that transfer agreement being
2 in place.

3 CHAIRWOMAN OLSON: But that's the function
4 of IDPH and not this Board?

5 I'm sure you have some comment.

6 MR. SHEETS: Well, I do briefly. But
7 I think I understand what Mr. Constantino is saying,
8 and I would wholeheartedly agree with that. There
9 are a lot of different licensure requirements, and
10 one of them is a transfer agreement. So all of
11 those would have to be met before the facility is
12 licensed.

13 CHAIRWOMAN OLSON: Well, the only reason
14 that's an issue right now as opposed to the other --
15 how many ever million we've looked at -- is because
16 in public comment that was brought to light.

17 MR. CONSTANTINO: Yeah. We received, from
18 the Applicants, about re- -- that if there was a
19 problem, that the Applicant would just call 911.
20 Well, you can't do that if you are a licensed ASTC.
21 You have to have a transfer agreement with the
22 hospital. You can't have that license without that
23 transfer agreement.

24 During public comment that issue was

1 brought up.

2 CHAIRWOMAN OLSON: I understand.

3 MEMBER GOYAL: Madam Chair, may I ask a
4 question?

5 CHAIRWOMAN OLSON: Sure.

6 MEMBER GOYAL: Mr. Constantino, is the rule
7 for transfer agreement 30 minutes, or is there a
8 different time period for --

9 MR. CONSTANTINO: I couldn't tell you,
10 Doctor.

11 MEMBER GOYAL: Would it be a reasonable
12 thing for the Board -- of course, I don't vote -- to
13 make their recommendation subject to the transfer
14 agreement even though it's another agency that has a
15 rule?

16 MR. CONSTANTINO: What -- what I --

17 MR. MORADO: I think I -- go ahead, Mike.

18 MR. CONSTANTINO: What I was trying to get
19 across to the Board was, if you approve this ASTC,
20 they have to have a transfer agreement in place.
21 I didn't want the Board to think that they would
22 approve this and there would be no transfer
23 agreement. That's all I'm trying to point out to
24 the Board.

1 That's an IDPH function but I thought the
2 Board needed to realize that transfer agreement will
3 be required if you approve this project.

4 MR. MORADO: Right. And I just -- to
5 piggyback on that, public comments that are made at
6 the beginning of the meeting, these folks are not
7 under oath. I'm not saying that they're telling --
8 saying deliberate lies, but they're not under oath,
9 and they're making allegations against folks who
10 have applications up, and you should take that
11 information as you will.

12 That said, I don't believe that it's
13 necessary to put any kind of condition on the permit
14 with regard to a transfer agreement.

15 MEMBER GOYAL: Okay.

16 CHAIRWOMAN OLSON: Comments for the Board,
17 please.

18 MR. SHEETS: I think we have to be sworn in.

19 CHAIRWOMAN OLSON: Oh, I'm sorry. I thought
20 you did that.

21 Thank you.

22 THE COURT REPORTER: Raise your right hands,
23 please.

24 (Three witnesses sworn.)

1 THE COURT REPORTER: Thank you. And please
2 print your names.

3 MR. SHEETS: Okay. Good afternoon.

4 Thank you, Mr. Constantino. I finally got
5 what you were saying. I appreciate that.

6 I have with me, Madam Chair, members of the
7 Board, essentially, the physician who is going to
8 run the project if approved, Dr. -- and forgive me,
9 Doctor, if I mispronounce your name -- Makhdoom.

10 DR. MAKHDOOM: That's right.

11 MR. SHEETS: And Dr. Makhdoom would like to
12 present some testimony with regard to the project.
13 And I also have with me Anne Cooper from my office,
14 as well.

15 DR. MAKHDOOM: Good afternoon, Madam Chairman
16 and members of the Board. My name is Dr. Zahoor
17 Makhdoom, and with me are Chuck Sheets and
18 Anne Cooper, as mentioned, our CON attorneys.

19 Thank you for the opportunity to appear
20 before the Board today regarding our CON
21 application. I would also like to thank Mayor
22 Mike Hamby of Carbondale who, unfortunately, cannot
23 be here but for his strong support of the project
24 and Senator David Luechtefeld, Congressman Mike

1 Bost, and candidate for Senate Sheila Simon and
2 other political leaders in the area, and my patients
3 Joe Ann Troue and Carole Klaine for their support
4 for this project.

5 I appreciate you taking time to provide the
6 community's point of view on the value of my
7 services to the community.

8 The description of the project. As
9 Mr. Constantino previously noted in his report, our
10 project is a single-specialty endoscopy center to be
11 located in Carbondale, Illinois. Importantly, this
12 project is limited to endoscopy, which, for a
13 gastroenterologist like myself, is a vital tool
14 I use to diagnose and treat patients in my practice.

15 Purpose of the project. The purpose of the
16 project -- compliance with IDPH requirements. This
17 project is before the Board because of Illinois
18 Department of Public Health requirements. While
19 I currently provide endoscopy services in
20 conjunction with the operation of my medical
21 practice as permitted by IDPH rules, the ratio of
22 surgical to nonsurgical procedures is increasing due
23 to my direct-access program, which makes it easier
24 for patients in good health to schedule endoscopy

1 procedures.

2 As you are probably aware, other physicians
3 have appeared before the Board to convert their
4 office-based surgical practices to ambulatory
5 surgical centers because IDPH regulations require a
6 facility to be licensed as an ambulatory surgical
7 center if more than 50 percent of the procedures in
8 the facility are surgical procedures.

9 Although we are currently at 45 percent of
10 surgical procedures, this percentage is growing, and
11 we are requesting Board approval to establish a
12 licensed endoscopy center to avoid a potential IDPH
13 compliance action in the future.

14 Further, as Mr. Constantino noted in the
15 staff report, IDPH does not license physicians'
16 offices. The procedures currently performed in my
17 medical office are regulated by the Illinois
18 Department of Financial and Professional Regulation
19 through my medical license.

20 As a family -- as a facility regulated by
21 the IDPH, the proposed endoscopy center will be
22 required to meet life safety code and quality
23 requirements of a licensed ambulatory surgical
24 center that will assure services we provide are on

1 par with other endoscopy centers in the state. This
2 is a good public health policy.

3 Expanding access to colonoscopy. Expanding
4 access to colonoscopy and upper GI endoscopy to
5 patients residing in and around Carbondale is an
6 integral part of this project. I have been a
7 practicing physician in Carbondale for 17 years and
8 have always given back to my community. I believe
9 I have an ethical obligation to serve patients
10 regardless of their situation and insurance status.

11 Colorectal cancer is the third most common
12 cancer and the second leading cancer death in both
13 genders in the United States. The lifetime risk of
14 developing colorectal cancer is nearly 5 percent.
15 The American Cancer Society projects that in 2016
16 there will be close to 135,000 new cases of
17 colorectal cancer and 50,000, unfortunately,
18 will die.

19 Consistent with national figures, colorectal
20 cancer is the second leading cause of cancer deaths
21 among Illinois adults, with over 2500 deaths
22 per year across the state. Early detection and
23 treatment of colorectal cancer is essential to
24 prevention and cure, and based on this, screening

1 colonoscopy is one of the most important elements of
2 the services we offer to our patients. There are
3 many initiatives to encourage colorectal cancer
4 screening, and better access to endoscopy is an
5 important element of this.

6 As your colleague Senator Demuzio knows
7 based on her involvement in colon cancer screening
8 advocacy, colonoscopy is the gold standard for
9 diagnosing and treating colon cancer, and every
10 individual aged 50 and older must be screened for
11 this potentially deadly disease every 10 years.

12 Current levels of colorectal cancer
13 screening in this country lag behind those of other
14 effective cancer screening tests. To increase
15 access to colorectal cancer screening, it must be
16 affordable. According to the latest annual consumer
17 survey conducted by the Federal Reserve Board,
18 47 percent of Americans would struggle to pay an
19 unexpected \$400 medical bill. According to the 2014
20 Illinois Hospital Report Card, the median charge for
21 a colonoscopy at the Carbondale-area hospitals is
22 approximately \$6,000.

23 Carbondale is a predominantly rural
24 community, and many residents have insurance with

1 high deductible and co-pays. For a patient with a
2 2500 or 5,000 upfront deductible and 20 percent
3 co-pay, the out-of-pocket cost of a colonoscopy
4 could be between 1200 and 5,000, which is out of
5 reach for many patients.

6 Without a low-cost option, patients are
7 faced with the difficult choice of foregoing this
8 important screening procedure or traveling 50 miles
9 to Cape Girardeau or other areas of Missouri where
10 the cost of these procedures is much lower.

11 I firmly believe better outcomes occur with
12 education, early detection, and treatment. To
13 increase the rates of colorectal cancer screening,
14 this must be affordable to all. To that end I've
15 agreed to provided free colonoscopies to patients
16 referred by Shawnee Health Center, offer colonoscopy
17 and upper GI endoscopy assistance programs for
18 uninsured and underinsured patients, and provide a
19 direct-access program to patients in good health who
20 want to save money on avoidable office visits.

21 In April of this year, I entered into an
22 arrangement to provide access to free colonoscopies
23 to uninsured patients who Shawnee Health Center
24 selects to refer to my clinic. Shawnee Health

1 Center strives to improve the health and welfare of
2 residents of southern Illinois by serving the needs
3 of vulnerable and underserved patients.

4 While the initial agreement provided for
5 five free colonoscopies per month, there is a
6 significantly increasing need for this service;
7 therefore, I've agreed to provide free colonoscopies
8 to any patient referred by Shawnee Health Center
9 even if the monthly cap is exceeded. I have already
10 opened my practice to these patients.

11 Additionally, through a colonoscopy-assist
12 program I offer, patients with means to pay but
13 with inadequate insurance coverage pay a flat fee of
14 \$1500, which covers my professional fee, anesthesia
15 fee, pathology fee, and facility fee, including
16 nursing costs.

17 In contrast, the \$6,000 fee noted above only
18 includes one of the four elements, the hospital
19 facility fee. Patients are separately billed for
20 the physician's fee separate, anesthesiology fee
21 separate, and pathology fee separate. Those are
22 roughly 2,000 to \$3,000, and that's added to the
23 cost to the patient.

24 Similar to the colonoscopy-assist program,

1 under the upper GI-assist program, patients pay a
2 flat \$900 fee for an upper GI endoscopy or EGD,
3 called. The flat fee covers the same scope of
4 services.

5 As previously noted, Carbondale is
6 predominantly rural and average income is 33,000 on
7 the record, with just over 50 percent of the
8 population being below the Federal poverty level.
9 For those patients who can't afford the flat fee,
10 they pay what they can afford and the balance
11 generally is written off. We have never hired, in
12 our 17 years of practice, any collection agencies.

13 As I first mentioned, I offer a direct-
14 access program, but I need to explain what that is.
15 The direct-access program is something I do in
16 coordination with a patient's primary care
17 physician. During general periodic exams a
18 primary care physician can help patients in good
19 health get an appointment for a screening
20 colonoscopy without first having a face-to-face
21 consultation for the required history and physical
22 with the gastroenterologist who will perform the
23 screening exam.

24 As the screening exam is required at 50 and

1 periodically thereafter, we seamlessly coordinate
2 these screenings with the patient's primary
3 physician, which avoids an extra doctor's
4 appointment. Because a nonsurgical visit to my
5 office doesn't occur when a patient is a direct-
6 access patient, it increases the ratios of surgical
7 versus nonsurgical encounters at my office. This
8 has required me to delay some of my surgeries at
9 certain points in time in order to ensure that in
10 any given week I don't do more surgical cases than
11 nonsurgical consults.

12 It is important to note both my medical
13 practice and the proposed endoscopy center cannot
14 qualify for tax exemption as the hospitals do
15 because we are a private business. What that means
16 is I, unlike the hospitals, do not avoid paying
17 taxes under Federal, state, property, and sales tax
18 laws nor am I eligible for tax-exempt bond financing
19 or to receive charitable contributions from donors.

20 According to a 2011 Health Affairs study,
21 the estimated value of Federal, state, and local tax
22 exemptions, tax-deductible charitable contributions
23 and tax-exempt financing was 24.6 billion in 2011.

24 Based upon Southern Illinois Hospital

1 Services' -- or SIH Services' -- 2014 990 return,
2 the system's net income was approximately
3 57 million. Assuming a corporate tax rate of
4 35 percent, SIHS' Federal tax liability would have
5 been 20 million; however, the collective charity
6 expense as reported in the annual hospital
7 questionnaire for the three hospitals controlled by
8 SIHS was approximately 13 million in 2014 or a
9 difference of 7 million between its potential
10 Federal income tax liability and amount of
11 charitable -- charity care provided.

12 Further, my charitable activities are
13 voluntary. I have no charitable obligations like
14 the hospitals. While my practice provides
15 significant amounts of charity care, we do not track
16 it because we are not required to report it, nor
17 does it provide us any financial benefits as it does
18 the hospitals.

19 Negative findings. I would like to address
20 the negative findings to the State Board report.

21 Service demand/treatment room need
22 assessment. This project has the same elements out
23 of compliance as all the other ambulatory surgical
24 center applications have had in the past; namely,

1 treatment room need assessment and utilization of
2 other providers in the area. This is also another
3 situation where the medical practice associated with
4 the project is running up against the surgical
5 versus nonsurgical encounter threshold. While
6 current Board rules provide that these referrals
7 cannot be taken into account to determine need for
8 the proposed facility, I'm seeking a license for my
9 endoscopy services to ensure my medical practice
10 complies with IDPH requirements relating to the
11 scope of care permitted for a gastroenterology
12 medical practice.

13 Further, the provision of endoscopy services
14 in an ambulatory surgical center setting is
15 consistent with the cost-containment mandate of the
16 Board by providing endoscopy services at a lower
17 cost to patients and payers compared to the hospital
18 setting.

19 Service accessibility/unnecessary
20 duplication and maldistribution of services. The
21 other two findings concern underutilization of
22 existing providers in the area. First, hospital
23 outpatient departments are not an appropriate
24 setting for endoscopy procedures that can be safely

1 performed in an ambulatory surgical treatment
2 center. In fact, payers like UnitedHealthcare,
3 seeking to improve cost efficiencies, now require
4 prior authorization for upper and lower
5 gastrointestinal procedures performed in a hospital
6 outpatient setting. No such prior approval is
7 required to do the procedure in an ambulatory
8 surgical center.

9 Further, hospitals that are more proactive
10 in ensuring lower cost access to services in the
11 community -- like Advocate, Northwest Community
12 Hospital, and Presence -- are investing in
13 ambulatory surgical centers to improve access to
14 lower-cost services for their communities.

15 As noted above, the median charge for a
16 colonoscopy at one of the Carbondale hospitals is
17 approximately 6,000 plus 2,000 additional costs on
18 part of physician fee, anesthesia fee, pathology
19 fee. The maximum charge for a colonoscopy at the
20 proposed endoscopy center will only be \$1500,
21 including all services.

22 Further, the proposed endoscopy center will
23 provide assistance programs to uninsured and
24 underinsured patients. Importantly, these

1 assistance programs will cover all of the costs of
2 the endoscopy procedure while the hospital financial
3 assistance programs will only provide the facility
4 fee, meaning the patient will still be responsible
5 for the physician fee, which is roughly around 550
6 or \$750; anesthesia fee, roughly around 500 fee;
7 pathology fee, roughly around 1200 to 1500 fee.

8 Further, there are no single-specialty
9 facilities in the service area that exclusively
10 provide endoscopy services with a focus on
11 colorectal cancer screening. Two surgical centers
12 are multispecialty centers and not only perform
13 gastrointestinal procedures. There are other
14 surgical procedures going on, too.

15 Physicians Surgical Center, which performs
16 gastrointestinal procedures, is operating at the
17 State Board standards. Marion Surgical Center and
18 Marion Healthcare are nearly 30 minutes away. If
19 I had to perform endoscopy procedures at other
20 providers in the area, it would be extremely
21 disruptive to my practice and the physician extender
22 care model we have developed.

23 I need to be at the office location to
24 supervise and collaborate with my physician

1 extenders and to most effectively and efficiently
2 deliver care to my patients.

3 Gastroenterology is a relatively small
4 specialty and only roughly 225 new fellows enter the
5 field each year. It is very difficult to recruit a
6 new doctor to a nonurban location in Illinois, so my
7 physician extenders are key to the delivery of GI
8 care in our community. I cannot effectively manage
9 my practice if I don't do my work at the same
10 location as them.

11 We are here today to require a CON permit so
12 we can pursue a license as required by IDPH in order
13 to continue this model where I perform my simple
14 endoscopy procedures in my office. We are not
15 moving cases away from hospitals. They have four of
16 their own gastroenterologists.

17 SIHS opposition. With regard to the
18 hospitals' opposition, I would like to add some
19 context to the comments. I'm the only independent
20 gastroenterologist in the Carbondale area and have
21 been in practice there for 17 years. I compete
22 directly with the primary hospital, which employs
23 its own gastroenterologists. Since hospitals are
24 permitted by Federal law to require their employed

1 physicians to refer to other hospital-employed
2 physicians, I'm in a tenuous position of potentially
3 losing my patient base to the hospital-employed
4 physicians. In fact, in 2014 I learned hospital-
5 employed physicians would be penalized for referring
6 patients to me for gastrointestinal services. It is
7 important to me to maintain my independence, as I
8 can better serve the Carbondale community as an
9 independent gastroenterologist. I should not be
10 forced to work with the health system that is trying
11 to strip me of my patient base due on their size and
12 power in the community.

13 SIHS System states there are existing
14 facilities in the area that are underutilized. As
15 noted previously, hospitals are not appropriate
16 settings for endoscopy procedures that can be safely
17 and cost effectively performed in an ambulatory
18 surgical center. Further, there is no single-
19 specialty facility in the service area focused on
20 colorectal cancer screening. Finally, traveling
21 30 minutes to perform endoscopy procedures at
22 underutilized facilities would be detrimental to my
23 model of care.

24 SIHS claims the in-office procedures should

1 not be used to justify the need for the project.

2 I want to reiterate that I'm seeking a license for
3 my endoscopy services to ensure my medical practice
4 complies with IDPH requirements.

5 SIHS claims the proposed endoscopy center
6 does not have a transfer agreement with a hospital
7 in the region. First, this is not -- a licensure
8 agreement -- requirement -- and -- not a CON permit
9 requirement. This is a licensure requirement and
10 not a CON requirement.

11 Secondly, my practice currently has a
12 patient transfer agreement with Heartland Regional
13 Medical Center, which is 15 minutes away from my
14 center, where I'm currently on admin staff.

15 Finally, with regard to the payer mix of the
16 proposed endoscopy center, I'm enrolled in Medicaid
17 and my current patient base is approximately
18 5 percent Medicaid; however, it is increasing every
19 day.

20 Based on the 2014 annual questionnaire, the
21 statewide percentage of total net revenue from
22 Medicaid for ambulatory surgical centers was
23 2.3 percent. The amount of Medicaid services we
24 project to provide is over twice the statewide

1 average of surgery centers.

2 Further, as previously discussed, we will
3 offer free colorectal cancer screening to patients
4 referred by Shawnee Health Center as well as
5 financial assistance to uninsured and underinsured
6 patients. In short, the proposed endoscopy center
7 will be a safety net provider of much needed
8 endoscopy services to patients residing in
9 Carbondale.

10 Thank you for your time and attention, and
11 I would be happy to answer any questions you have.

12 CHAIRWOMAN OLSON: Questions from Board
13 members?

14 Doctor.

15 MEMBER GOYAL: Thank you, Madam Chair, for
16 the opportunity to learn more.

17 Thank you, Dr. Makhdoom, for trying to do
18 something that is not necessarily common in your
19 area.

20 DR. MAKHDOOM: Thank you.

21 MEMBER GOYAL: So I have a series of
22 questions and please understand I represent
23 Medicaid --

24 DR. MAKHDOOM: Sure.

1 MEMBER GOYAL: -- on this Board and I don't
2 have a vote so --

3 MR. SHEETS: Doctor, can I interrupt you for
4 a minute?

5 MEMBER GOYAL: It's short but go ahead.

6 MR. SHEETS: You said that before, you
7 represent Medicaid --

8 MEMBER GOYAL: I do.

9 MR. SHEETS: -- but --

10 CHAIRWOMAN OLSON: He does.

11 MR. SHEETS: Because I'm just a little --
12 you're Department of Public Health; correct?

13 MEMBER GOYAL: No, I'm not.

14 MR. SHEETS: Oh, you're not?

15 CHAIRWOMAN OLSON: That's Bill.

16 MEMBER GOYAL: I look like it but I don't.

17 MR. SHEETS: My apologies.

18 MEMBER GOYAL: No problem.

19 So my first question to you is, in these
20 documents that you submitted, you indicate that
21 there's is 5 percent Medicaid and there is
22 10 percent self-pay, meaning uninsured, and you also
23 indicated in your comments that approximately
24 50 percent of the population is below poverty.

1 Can you match that with your practice, what
2 the demand will be?

3 DR. MAKHDOOM: Yes. The numbers we
4 presented are from 2015, and '16 has just almost
5 doubled. We haven't assembled the numbers.

6 MEMBER GOYAL: So "double" means you have
7 10 percent Medicaid?

8 DR. MAKHDOOM: 10 percent or even more. We
9 are doing, every day, three to four patients of
10 public aid on the record in 2016.

11 MEMBER GOYAL: Okay.

12 DR. MAKHDOOM: Now, hospital has
13 multispecialty. They have L&D, ob-gyn, surgery,
14 geriatrics, young medicine, family medicine, so the
15 number of public aid is high. I am one single
16 specialty. So only GI services, we have that
17 number.

18 MEMBER GOYAL: Yeah, I understand.

19 What is the wait time for somebody to
20 schedule a screening colonoscopy in your practice
21 today once the request is received?

22 DR. MAKHDOOM: Now, if the request is coming
23 from Shawnee Health physician, they all go with the
24 family history. If the history is strong, within a

1 week we scope. This is screening. If a patient
2 approaches, within a week we scope. That's a
3 screening colonoscopy.

4 MEMBER GOYAL: Okay. So the wait time
5 normally is --

6 DR. MAKHDOOM: One week.

7 MEMBER GOYAL: -- a week or less?

8 DR. MAKHDOOM: One week or less.

9 MEMBER GOYAL: Okay. And then my second
10 question is, currently -- the way I understand the
11 system -- for all of your patients, including
12 commercial, Medicaid, or whatever, you're not able
13 to charge a facility fee.

14 DR. MAKHDOOM: No.

15 MEMBER GOYAL: Right. With the ASTC
16 everybody will pay a facility fee unless it's one of
17 your free patients?

18 DR. MAKHDOOM: They do, but that will
19 cover -- not uninsured patients. Now, I'm not sure
20 how many insurances are going to pay that.

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

22 DR. MAKHDOOM: We have a flat-fee program,
23 colonoscopy-assist and EGD-assist programs, so that
24 flat fee is \$1500, including all services, for

1 colonoscopy and \$900 for upper endoscopy, including
2 all services.

3 MEMBER GOYAL: Right. So it -- your answer
4 to my question is that, by having an ASTC, you think
5 you'd be able to serve more uninsured and Medicaid
6 patients --

7 DR. MAKHDOOM: Absolutely.

8 MEMBER GOYAL: -- however, the cost of care
9 for everybody else will go up because now their bill
10 will be itemized to show a facility fee? Am I
11 incorrect in saying that?

12 MR. SHEETS: If the patient were to come to
13 his physician office practice, that is correct,
14 Doctor. But if the patient were to go somewhere
15 else because he's in --

16 MEMBER GOYAL: I'm not comparing --

17 MR. SHEETS: -- close to 50 percent, you
18 know, then they would have to be referred out, and
19 then they would have to pay that fee anyway.

20 But, in theory, you're correct if they came
21 to his physician office practice now.

22 MEMBER GOYAL: So if these numbers are
23 correct that you supplied -- and you've said that
24 the numbers had changed a little bit in the last --

1 DR. MAKHDOOM: In '16, 2016.

2 MEMBER GOYAL: Right. So let's say if the
3 numbers were what you presented, 85 percent of your
4 patients with those previous numbers would pay
5 more -- will -- it will become more expensive for
6 them as opposed to the 15 percent according to these
7 numbers? Am I extrapolating accurately?

8 DR. MAKHDOOM: No. My maximum fee is 1500
9 whether from insurance or assist plans or whatever.
10 It is not more than 1500.

11 MEMBER GOYAL: For colonoscopy?

12 DR. MAKHDOOM: For colonoscopy.

13 MEMBER GOYAL: So may I ask -- and it will
14 help me tremendously to understand your colonoscopy-
15 assist program.

16 DR. MAKHDOOM: Yes.

17 MEMBER GOYAL: The charge that you have
18 here, \$1500 for colonoscopy, 900 for upper
19 endoscopy -- I'm curious. What do you charge and
20 get paid from commercial and Medicare patients for
21 the same procedure?

22 DR. MAKHDOOM: Sure. Commercial pay me \$850
23 but they pay me --

24 MEMBER GOYAL: For colonoscopy?

1 DR. MAKHDOOM: For EDG.

2 MEMBER GOYAL: Okay.

3 DR. MAKHDOOM: But they pay me for pathology
4 separate.

5 MEMBER GOYAL: But everybody doesn't need
6 the pathology.

7 DR. MAKHDOOM: Mostly do.

8 MEMBER GOYAL: Really?

9 DR. MAKHDOOM: Well, we are looking for
10 polyps. At our age you would be surprised. More
11 than half have pathology. Pathology is a simple
12 procedure to move. We are subject to pathology --

13 MEMBER GOYAL: Okay.

14 DR. MAKHDOOM: -- so our services include
15 pathology.

16 And on colonoscopy commercial pays me -- in
17 fact, on multiple tests -- not more than \$1200.

18 MEMBER GOYAL: Okay. So why is your
19 colonoscopy-assist program cheaper when you're
20 charging \$1500 for colonoscopy and 900 for upper?

21 DR. MAKHDOOM: We want to serve the
22 community.

23 MEMBER GOYAL: No, no. But didn't you just
24 say that Medicare pays you --

1 DR. MAKHDOOM: No. Medicare pays me
2 nothing. Medicare pays me \$250 for the scope, and
3 they pay separate for pathology if there's
4 pathology, as you said.

5 MEMBER GOYAL: Right. But here you're
6 getting a bundled --

7 DR. MAKHDOOM: Bundled.

8 MEMBER GOYAL: -- payment, which is about
9 eight times more than Medicare.

10 DR. MAKHDOOM: Now, which are you
11 mentioning? We showed everything.

12 MEMBER GOYAL: Let's talk about colonoscopy.

13 DR. MAKHDOOM: Yes.

14 MEMBER GOYAL: Your colonoscopy-assist
15 program, you're charging them \$1500.

16 DR. MAKHDOOM: 15. Absolutely.

17 MEMBER GOYAL: And you think it's a
18 community service and we appreciate that.

19 DR. MAKHDOOM: Yes.

20 MEMBER GOYAL: So when you do a colonoscopy
21 on a Medicare patient, did you just say that you're
22 being paid \$250?

23 DR. MAKHDOOM: No -- if there's nothing. If
24 there's --

1 MEMBER GOYAL: Right. Right. If there
2 is --

3 DR. MAKHDOOM: Exactly.

4 So maximum per -- Medicare pays for only
5 colonoscopies, about 450 or 500, but then they add
6 on pathology if you have pathology.

7 MEMBER GOYAL: I understand that but
8 that's -- usually pathology's free.

9 DR. MAKHDOOM: But we have in-house
10 pathology --

11 MEMBER GOYAL: Right.

12 DR. MAKHDOOM: -- and that's why I'm able to
13 provide a flat fee.

14 MEMBER GOYAL: Yeah. You've bundled them?

15 DR. MAKHDOOM: Yes, for bundled.

16 MEMBER GOYAL: But your bundled price, the
17 fee is higher than what Medicare and Medicaid are
18 paying you --

19 MR. SHEETS: I think I know what you're
20 asking, Doctor --

21 MEMBER GOYAL: -- correct?

22 MR. SHEETS: -- and you're a hundred percent
23 correct.

24 MEMBER GOYAL: Okay.

1 MR. SHEETS: The only thing I would mention
2 is, when you get a facility fee, a physician -- if
3 you get a physician fee in a setting that the doctor
4 has now, it is a larger physician fee than you would
5 get when you have a facility fee that goes along
6 with it.

7 So it's not just an add-on. The physician
8 fee goes down when there's a facility fee associated
9 with it.

10 MEMBER GOYAL: Right. Yes.

11 MR. SHEETS: Just so you know.

12 MEMBER GOYAL: Yeah, I understand that.

13 So I have a need to ask you this one
14 question that -- I'm totally unclear.

15 What is your relationship -- why did you
16 resign from these other hospitals?

17 DR. MAKHDOOM: Now, I served them 13 years.
18 And while I was there, they started recruiting their
19 own gastroenterologists, and they told me that they
20 have to refer to their own gastroenterologists, so
21 they took away two days from me.

22 And they told me to go to St. Joseph's and
23 another facility close by. But then Tuesday was the
24 only day they could do now for a urologist, so I had

1 to take to my office. That's where the system
2 started. When I started practicing in my office --
3 so I would do like a -- 150 in my office, 4 times in
4 the hospital.

5 But then sometimes I do one spouse in my
6 office and the other spouse in hospital, and then
7 the hospital bill would be so high that the spouse
8 would come in very angry, "Why didn't you do this in
9 your practice? Because I cannot afford this bill."

10 So -- and then they increased their number
11 of recruitment -- now they have four. They wanted
12 to work the same days, so I had to do something, so
13 I started doing them at my office.

14 And you would be surprised to see how they
15 were allocated, if they see the hospital bill versus
16 their spouse's that would be done in my office. So
17 that's why we started doing it.

18 And they mentioned the opposition. I used
19 to take Medicare patients with advanced conditions,
20 where anesthesia and other care was needed at the
21 hospital level. Initially I did have that capacity
22 in my office but now I don't. So advanced cases
23 I used to take to hospital, patient -- facility.

24 MEMBER GOYAL: Thank you, Doctor.

1 DR. MAKHDOOM: Thank you.

2 CHAIRWOMAN OLSON: Other questions?

3 MEMBER SEWELL: Yes.

4 I'm looking at the State agency report, and
5 it's the treatment room need assessment criteria.

6 And you stated in your testimony that, you
7 know, what you're doing is consistent with what
8 other applications we've received were with respect
9 to this criteria, but the -- according to the State
10 agency report, it's suggesting that, based on your
11 demand over the last two years, you only justify one
12 procedure room but you're proposing two.

13 So can you give me a reason you're proposing
14 two other than the fact that all the other people do
15 that?

16 DR. MAKHDOOM: No. We initially started in
17 one procedure room, but the ADI -- unfortunately,
18 sometimes the machine will be down or whatever, then
19 my patients will wait.

20 So I created another room, and I have a
21 duplicate system in the room. So if this system is
22 not working, I can just go to the other room.

23 But now if you look at the two rooms, the
24 flow is so quick. Patients are seen quicker, no

1 long wait. And while you finish this, other patient
2 is being wheeled into the other room. So it is
3 really -- in every facility two rooms are justified
4 for better services. But if I had one system only,
5 room, and something goes wrong with the machines,
6 whatever, then I'm stuck.

7 So I needed another room. I have a
8 duplicate system there, too. That helps my
9 patients.

10 MEMBER SEWELL: So it's to reduce patient
11 wait time?

12 DR. MAKHDOOM: Wait time.

13 MEMBER SEWELL: Is there some standard for
14 that?

15 DR. MAKHDOOM: No. The standards are the
16 same. We've got two times Joint Commission
17 approved, accredited, and two times ASGE or
18 endoscopy society accredited for excellent center.
19 We hired an architect who is familiar with IDPH
20 rules and, according to him, he's satisfied we have
21 enough room to put two rooms and equipment in there.

22 MEMBER SEWELL: Well, I'd like to ask
23 Mr. Constantino.

24 When you looked at their demand and you

1 determined that one procedure room was needed, was
2 there any slack in that at all or -- how did you
3 account for that?

4 MR. CONSTANTINO: Well, we can only accept
5 those procedures that were performed in a licensed
6 ASTC or a hospital --

7 MEMBER SEWELL: I see.

8 MR. CONSTANTINO: -- and the 462 procedures
9 were performed in an ASTC or a hospital, and that
10 justifies the one procedure room, not two, as was
11 requested.

12 MEMBER SEWELL: Okay.

13 CHAIRWOMAN OLSON: What would you estimate
14 the turnover time of those rooms is? As somebody
15 who runs clinics, I can't imagine -- you have to
16 account for turnover time and, like you said,
17 equipment being down -- I can't imagine having one.

18 DR. MAKHDOOM: Upper endoscopy roughly take
19 the doctor 5 to 7 minutes, roughly, 10 minutes. And
20 then take -- the patient is wheeled out, and then
21 I have an area where recovery is close by, and from
22 there patient is wheeled in. Colonoscopy takes us
23 20 minutes.

24 CHAIRWOMAN OLSON: No, I'm asking -- in

1 between patients. What does it take you, like --
2 I think in hospital hours it's like 30 minutes --
3 right? -- to turn -- 20 to 30 minutes to turn that
4 room over so it's ready for the next patient --

5 DR. MAKHDOOM: No, we have -- yeah. We
6 have -- in and out takes 1 hour 30 minutes.

7 CHAIRWOMAN OLSON: Okay. Do you know what
8 I'm --

9 MR. SHEETS: I think I know what you're
10 saying.

11 CHAIRWOMAN OLSON: You're not answering the
12 question.

13 MR. SHEETS: I think what she wants to know
14 is, once the patient gets wheeled into the room,
15 another patient's wheeled out, how long does it take
16 to get that room ready for the next patient?

17 CHAIRWOMAN OLSON: I'm trying to say I don't
18 know how you could -- from a workflow standpoint it
19 would make no sense to have one room because I'm
20 guessing it takes you 25 to 30 minutes to roll that
21 room over after the first patient's rolled out
22 before the second patient can come in.

23 DR. MAKHDOOM: Yeah.

24 CHAIRWOMAN OLSON: So your workflow -- now,

1 what you're going to do is, while they're turning
2 over that first room, you're going to take the next
3 patient in the second room, and then the first
4 room's ready for you again, and then the second
5 room's ready for you.

6 DR. MAKHDOOM: Yes. Exactly. Exactly.

7 CHAIRWOMAN OLSON: Sounds like it's like 20,
8 25 minutes, I would suspect.

9 MEMBER MC GLASSON: Doctor, you mentioned
10 your work with Shawnee Health Service. There are
11 some similar organizations in the Carbondale area.
12 Are you exclusively offering that service to Shawnee
13 or --

14 DR. MAKHDOOM: We offered a similar service
15 to Dixon Health Center, but then they were
16 shrinking, so they requested us to liaison with
17 Shawnee alone because they are losing the population
18 and their number of large services have been
19 falling, too. So the offer was available at other
20 facilities.

21 CHAIRWOMAN OLSON: Other questions?

22 (No response.)

23 CHAIRWOMAN OLSON: Actually --

24 MR. SHEETS: You know, I hate to even bring

1 this up but I'm going to --

2 CHAIRWOMAN OLSON: Uh-huh.

3 MR. SHEETS: -- because I just turned 60 so
4 all of this is really strikingly familiar to me.

5 When I was 50 I had my first one, and I went
6 to a hospital, the same doctor's practice, DuPage
7 Medical Group; a lot of people know them. And when
8 it was time to schedule the second, because I turned
9 60, I went to a surgery center in Lombard.

10 So I think that the biggest thing that I can
11 emphasize in the doctor's presentation is that, you
12 know, the Blue Cross Blue Shields of the world are
13 not approving these procedures in hospitals without
14 some preapproval process because they believe the
15 charges are higher.

16 So, again, we're looking at a change in how
17 these particular procedures are provided, and
18 I would just emphasize this is a single-specialty
19 surgery center in southern Illinois and the doctor
20 just wants to be able to treat his patients and meet
21 the IDPH requirements.

22 CHAIRWOMAN OLSON: So while you're still on
23 that -- because I have a question.

24 So to your point there -- and I believe,

1 Doctor, what you stated was that there's one other
2 ASTC in Carbondale who does colonoscopies in the
3 ASTC but they're over capacity at this point.

4 Did I get that correctly?

5 DR. MAKHDOOM: I -- this is a multispecialty
6 center, is not single specialty. They do all
7 services.

8 CHAIRWOMAN OLSON: And they're over --
9 they're over capacity?

10 So if I wanted to -- if I -- because I'm 60,
11 too -- 60, also. Make sure we got that on the
12 record.

13 If I wanted to have a colonoscopy and lived
14 in Carbondale, I don't want to go to a hospital and
15 have it, my insurance doesn't want me to go to the
16 hospital to have it, where can I go -- right now,
17 today -- in Carbondale?

18 DR. MAKHDOOM: My center.

19 CHAIRWOMAN OLSON: So the multispecialty
20 doesn't do it, either? Or they do do it but you
21 would be the only single specialty?

22 DR. MAKHDOOM: That's right.

23 CHAIRWOMAN OLSON: And then -- and so you're
24 the only, at this point, independent GI doc in --

1 DR. MAKHDOOM: The only independent in
2 Carbondale.

3 CHAIRWOMAN OLSON: Every other GI doc in
4 Carbondale --

5 DR. MAKHDOOM: -- is a hospital employee.

6 CHAIRWOMAN OLSON: And you did say that
7 you're on active staff at Heartland Hospital?

8 DR. MAKHDOOM: Heartland Hospital, yes.

9 CHAIRWOMAN OLSON: And does that require you
10 to take call?

11 DR. MAKHDOOM: Yes.

12 CHAIRWOMAN OLSON: Okay. So if you were on
13 active staff at all these other hospitals, would you
14 have to take call at all these hospitals?

15 DR. MAKHDOOM: No. With Heartland, yeah.

16 CHAIRWOMAN OLSON: But you don't -- if
17 you're active staff with one hospital, you don't --

18 DR. MAKHDOOM: One hospital.

19 CHAIRWOMAN OLSON: And then I want -- Mike,
20 this is a question for you. I want some
21 clarification on this IDPH issue.

22 So can you explain that to me a little bit
23 more? He's really -- if he does any more
24 colonoscopies the way he is right now, he's going to

1 be out of IDPH compliance unless he's an ASTC?

2 Is that what I'm understanding from that?

3 MR. CONSTANTINO: That's not my
4 interpretation of that, Kath. Okay? I don't view
5 that requirement in that fashion.

6 And I've talked to IDPH about this, and
7 I hope -- I tried to explain it in this --

8 CHAIRWOMAN OLSON: And I wrote next to your
9 explanation "Huh?" question mark.

10 MR. CONSTANTINO: They look at everything
11 performed at that site, IDPH does -- visits,
12 procedures, everything -- to determine the
13 50 percent criteria.

14 MR. SHEETS: I think Anne would be better
15 suited to answer this because I think she
16 understands how IDPH defines "procedures."

17 Is that right, Anne?

18 MS. COOPER: Basically, what we did in order
19 to come up with the 45 percent threshold is we
20 looked at all the physician encounters, which is
21 essentially the surgical procedures that are being
22 performed as well as the consult -- the consults.
23 Dr. Makhdoom also does other procedures that are
24 related to Crohn's disease. And so any kind of

1 procedures that are performed by Dr. Makhdoom or his
2 physician extenders, we looked at that in
3 determining what the level of surgical versus
4 nonsurgical activities were.

5 And so based upon that -- and a lot of this
6 is driven by, as Dr. Makhdoom had mentioned, his
7 direct-access program whereby patients who are in
8 good health can coordinate with their PCP and
9 Dr. Makhdoom to actually have a colonoscopy without
10 having to come into the office to get a consult. So
11 it's actually driving the number of physician
12 consults down and then the physician -- and the
13 actual procedures up, and that's kind of why we're
14 kind of butting up against that 50 percent
15 threshold.

16 CHAIRWOMAN OLSON: And your concern is that,
17 if you exceed that, you're going to be in trouble
18 with IDPH, and you don't want to go over that
19 threshold?

20 MS. COOPER: Correct. And, basically -- and
21 as Dr. Makhdoom has said in his presentation, there
22 are some times during a week where he has more
23 endoscopies scheduled than consults. And so to stay
24 within that 50 percent threshold, he'll push some of

1 his colonoscopies or other endoscopic procedures off
2 to another week in order to stay within that
3 threshold.

4 So he's very aware of that threshold, and
5 he's butting up against it.

6 CHAIRWOMAN OLSON: Did IDPH weigh in? Or we
7 didn't ask them to?

8 MR. CONSTANTINO: I talked to Karen Senger,
9 who's in charge of that department, and that's not
10 the interpretation she gave me. Okay? I'm telling
11 you all --

12 CHAIRWOMAN OLSON: So I understand what
13 their interpretation is. I don't understand what
14 yours is.

15 MR. CONSTANTINO: The activity -- all
16 activity at that site needs to be taken into
17 consideration when you determine the 50 percent
18 threshold. You could dispense an aspirin and that's
19 an activity. You could have a patient visit and
20 that would be an activity. That's how IDPH has
21 interpreted that rule for years.

22 The other alternative -- if you don't
23 approve this, the doctor would have to send -- to
24 do -- perform some of these procedures at a hospital

1 or another facility if they -- if he feels he's in
2 danger of going over the 50 percent.

3 CHAIRWOMAN OLSON: Which, to your point,
4 Chuck, a lot of insurances don't want to do --
5 I know mine won't. I mean, I have to have a heart
6 thing or something else going on or I -- they won't
7 do it in a hospital.

8 MR. SHEETS: There has to be some
9 complication or something.

10 CHAIRWOMAN OLSON: Right.

11 Other questions?

12 MEMBER MC GLASSON: Yes, Madam Chair,
13 although I'm not sure if it's a question or statement.

14 THE COURT REPORTER: Could you use your mic,
15 please?

16 MEMBER MC GLASSON: Yes.

17 I'm not sure if it's a question or a
18 statement, Doctor.

19 You are going to be such more reasonably
20 priced than anybody in your area. If you were to
21 become so terribly busy that it strains the
22 50 percent, is there a way we can be assured that
23 the charity care and the reduced care patients are
24 not going to be pushed out of the way?

1 DR. MAKHDOOM: I can give you assurance.
2 I've been doing these services and involved in
3 community service for 17 years. Outside a very good
4 practice, my purpose is to serve my community and
5 I belong there. I can strongly assure you that.

6 CHAIRWOMAN OLSON: Other questions or
7 comments?

8 (No response.)

9 CHAIRWOMAN OLSON: Seeing none, I'll ask for
10 a roll call vote.

11 MR. ROATE: Thank you, Madam Chair.

12 Motion made by Mr. Sewell; seconded by
13 Mr. Galassie.

14 Mr. Galassie.

15 MEMBER GALASSIE: I'll be voting no based
16 upon staff concerns and financing.

17 MR. ROATE: Thank you.

18 Justice Greiman.

19 MEMBER GREIMAN: I vote aye.

20 MR. ROATE: Thank you.

21 Mr. Johnson.

22 MEMBER JOHNSON: I vote no based on the
23 staff report.

24 MR. ROATE: Thank you.

1 Mr. McGlasson.

2 MEMBER MC GLASSON: I will vote yes based on
3 the fact that I believe it's a pioneering effort.

4 MR. ROATE: Thank you.

5 Mr. Sewell.

6 MEMBER SEWELL: I'm going to pass. I don't
7 completely understand all the issues in this
8 program. It sounds like there are some systems
9 alternatives to what's being proposed.

10 I'm just not sure so I'm going to pass.

11 MR. ROATE: Thank you, sir.

12 Madam Chair.

13 CHAIRWOMAN OLSON: Yes.

14 This is a hard one for me, but I'm
15 actually -- I'm actually going to vote yes based
16 upon a couple different factors.

17 First of all, as somebody who runs five
18 clinics, I can easily, in my head, understand why
19 you have to have two rooms instead of one. You
20 can't have patients sitting, waiting 25 minutes for
21 the staff to clean it before the next procedure, so
22 I can explain that.

23 I also -- I don't fully understand the ASTC
24 issue, but I understand what he's running up against

1 when I sit and think of trying to schedule 11 docs
2 for a day and I have to go, "Okay. I can only have
3 so many appointments that are actual procedures, and
4 if I go over 50 percent of what are actual
5 procedures, I've got to push those procedures out
6 and do more exams or more" -- I don't know how you
7 can run a practice that way. I guess I don't wholly
8 understand the rule, but I can't -- I can't wrap my
9 head around it.

10 But I think -- I totally understand the
11 insurance thing because I've just been through this.
12 My insurance will not approve me to have a
13 colonoscopy in a hospital. So if I lived in
14 Carbondale, I'd drive out of town to have that done.
15 It's not a great thing to do anyway, but to have to
16 drive out of town to do it -- so I -- for those
17 reasons I vote yes.

18 MR. ROATE: Thank you, Madam Chair.

19 That's 3 votes in the affirmative; 2 votes
20 in the negative; 1 vote to pass.

21 CHAIRWOMAN OLSON: Motion fails.

22 MR. SHEETS: Thank you.

23 MR. MORADO: You're going to be receiving an
24 intent to deny. You'll have an opportunity to

1 provide more information. If you'd like, you can
2 appear again before the Board.

3 MR. SHEETS: Thank you.

4 MS. COOPER: Thank you.

5 CHAIRWOMAN OLSON: Thank you.

6 We are going to take a 10-minute break. It
7 is 2:10. We'll be back here at 2:20.

8 (A recess was taken from 2:10 p.m. to
9 2:20 p.m.)

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1 CHAIRWOMAN OLSON: Next we have
2 Project 16-011, Northbrook Behavioral Health
3 Hospital.

4 May I have a motion to approve
5 Project 16-011, Northbrook Behavioral Hospital, to
6 establish a 100-bed acute mental illness hospital.

7 MEMBER JOHNSON: So moved.

8 MEMBER SEWELL: Second.

9 CHAIRWOMAN OLSON: Second, please --
10 thank you.

11 The Applicant will be sworn in.

12 (Six witnesses sworn.)

13 THE COURT REPORTER: Thank you.

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

16 MR. CONSTANTINO: Thank you, Madam Chairwoman.

17 The Applicants are proposing to establish a
18 100-bed acute mental illness hospital in Northbrook,
19 Illinois. The proposed project cost is
20 approximately \$31.3 million. The anticipated
21 completion date is December 31st, 2017.

22 There was no public hearing; we did not
23 receive any opposition letters. We did have
24 findings and we had a comment on the State Board

1 staff report that should be in front of you, 16-11.

2 You received this by e-mail, also.

3 MR. MORADO: Was that submission timely?

4 MR. CONSTANTINO: Yes.

5 MR. MORADO: Thank you.

6 MR. CONSTANTINO: Thank you, Madam Chair.

7 CHAIRWOMAN OLSON: Thank you, Mike.

8 Comments for the Board?

9 Do you want to introduce your group there
10 first?

11 MR. KNIERY: Absolutely. Thank you,
12 Madam Chairman.

13 My name is John Kniery. I'm a certificate
14 of need consultant for the project. I am pleased to
15 have with me today Mr. Rich -- Dr. Richard Kresch.
16 He is the president and CEO of the Applicant
17 entities.

18 To my immediate right is Martina Sze,
19 executive vice president of US HealthVest. To our
20 far right is Mr. Marc Silberman, legal counsel to
21 the project; James Cha, the chief financial officer
22 for the Applicant; and on my far left is Miro
23 Petrovic. He's the architect and he's the vice
24 president of physical facilities.

1 CHAIRWOMAN OLSON: Thank you.

2 DR. KRESCH: So, first, I would like to
3 thank the committee and the staff for taking the
4 time to consider our application and to also thank
5 those of you who were able to attend the grand
6 opening of Chicago Behavioral Hospital and get an
7 idea of what we were able to accomplish there.

8 We are a company that has spent the last
9 30 years developing innovative and patient-centered
10 approaches to the care of acute mental illness.

11 MEMBER GREIMAN: Will you talk closer to
12 the mic.

13 CHAIRWOMAN OLSON: We can't hear you.

14 DR. KRESCH: Okay.

15 So we have spent the last 30 years devoted
16 to developing new and innovative methods of both
17 providing care and the delivery of that care to
18 patients in need and have focused on reaching out to
19 individual groups of patients so that they can
20 receive care that's tailored to their needs instead
21 of a general standard type of treatment that applies
22 to a broad group of patients.

23 An acute mental illness hospital is
24 different from a general medical/surgical hospital

1 in that we offer a very limited scope of service and
2 our referral patterns are somewhat different. And
3 as a result of the nature of our business and
4 particularly the focus of US HealthVest and its
5 hospitals that we own and operate, we become a very
6 community-based organization.

7 We, as a practice in all of our facilities,
8 accept every insurance -- Medicaid and Medicare,
9 TRICARE, all insurances -- safety net type of
10 programs that exist in the communities we serve. We
11 do not turn away any patient regardless of ability
12 to pay or type of insurance coverage that they have.

13 So our referral base is pretty broad and
14 it's very community based, ranging from the police
15 to schools, to social service agencies, to
16 physicians and other practitioners in the
17 communities, and, to a large extent -- and probably
18 our biggest single referrer are the emergency
19 departments of nearby med/surg hospitals.

20 Everyone who is aware and listens to TV or
21 reads the newspapers is very aware of the shortage
22 of available inpatient beds for treatment of
23 high-acuity, at-risk acute mental illness patients.
24 As a result -- and you heard from many of the people

1 who spoke earlier today -- patients are often kept
2 in an inhumane fashion for days at a time, sometimes
3 chained to a bed in a psych -- in a medical/surgical
4 hospital emergency room for lack of better
5 alternatives. The need for access is great, and it
6 spreads across the entire region.

7 In my own experience -- and it's not really
8 a scientific observation but a practical one -- it
9 appears that the utilization rates for high-acuity
10 mental health services, including inpatient
11 psychiatric beds, has been increasing quite
12 dramatically over the past decade and will continue
13 to do so.

14 The good news is that many people who
15 previously could not access care currently can
16 because of the Affordable Care Act. And this has
17 resulted in a wider acceptance and wider utilization
18 of all kinds of mental health services, but our
19 focus is on inpatient, and that's what we see.

20 We are an experienced group as far as the
21 development and operation of hospitals. Were
22 Northbrook to be approved, it would be our
23 17th psychiatric hospital. We have shown -- I think
24 CBH is an example of our understanding of the

1 community needs, in that we acquired a hospital that
2 was in such poor condition in all respects that it
3 was about to close. It was literally within days of
4 closing, and, within six months, we have been able
5 to rehabilitate it to the point where it was
6 self-sustaining financially.

7 Within a year, less than a year, we were
8 able to renovate the entire half of the building to
9 provide high-quality, attractive, efficient patient
10 care rooms and to update life safety equipment in
11 the remaining part of the hospital.

12 During this time, in spite of the
13 construction going on, the hospital was operating in
14 full capacity of the available beds. And now that
15 we've opened, as of February, the newly renovated
16 beds and are able to operate at full capacity, we
17 are again finding ourselves almost full.

18 We -- an example, the hospital's licensed
19 for 125 beds. We have been consistently running
20 over the past few months -- since the new -- since
21 the renovated areas have opened -- census in the
22 one-teens. So essentially -- the hospital's
23 essentially full in just a little over a year's
24 operation.

1 In thinking about this project, because of
2 this unprecedented -- in our experience --
3 unprecedented demand, we began looking further out
4 in the CBH market area and service areas, and we
5 realized that there was also a shortage of beds to
6 the north of us.

7 And we looked at the two in Lake County and
8 northern Cook County, and, unfortunately, the number
9 of available beds, according to the bed -- State
10 bed-need calculation, was very low in each district
11 and, as a result, it would not be feasible to
12 establish very small -- we're talking 20-, 30-bed
13 facilities. A facility of that size is not viable.
14 The only conceivable way those beds could be
15 utilized would be as a unit in a med/surg hospital.
16 That is also unlikely to occur.

17 And so we had the idea that, well, a way to
18 provide these needed beds would be to combine those
19 two regions, which are adjacent to each other,
20 establish a facility that's at the center and
21 intersects the two regions, and we did. We found a
22 location that is right on the borderline of the
23 two regions, would equally serve them, and if --
24 with putting the available beds and adding a few so

1 that the hospital would be economically secure and
2 we could be assured that it would remain open and
3 viable for years to come, we came up with the idea
4 of combining the two regions, which we understand is
5 not consistent with policy, but we think that it's
6 consistent with good sense and a commitment to serve
7 people in need.

8 We -- an issue came up and I will address
9 it. James will talk more about it, but our -- our
10 organization has been a successful organization. We
11 have specialized, as I mentioned, in de novo
12 starting of new hospitals. We've done six. And in
13 our acquisition, similar to CBH, we're -- the old
14 Maryville -- we focused on the acquisition of
15 distressed properties, and we have had a hundred
16 percent success rate in turning around all of the
17 distressed hospitals we have acquired. And as a
18 result, we have found it relatively easy to gain
19 access to investment capital.

20 When the financial statement was submitted
21 with the application in December, it reflected our
22 situation at the time. Our strategy for developing
23 new facilities to ensure that they are developed
24 with only quality in mind and not to worry about

1 financial aspects of the development is to make sure
2 that we have sufficient funds to complete the
3 project before we start it. So, as a result, we
4 have been successful since the end of last year and
5 have raised an additional \$59 million in equity
6 investment from our investor group and have at this
7 point significantly more capital than it would
8 require to build and develop Northbrook.

9 So with that, I'd like to turn it over to
10 James, who can provide a little more detail.

11 MR. CHA: So, first of all, certainly there
12 was a concern raised in the staff report regarding
13 the availability of funds, and, you know, certainly
14 we apologize for any confusion therein.

15 There -- as Dr. Kresch mentioned, the
16 audited financial results that we had at the time
17 did, indeed, accurately reflect the resources we had
18 available. Over the course of this year, however,
19 we have been successful in raising additional equity
20 capital. As Dr. Kresch mentioned, we raised
21 59 million, of which 9 million has currently been
22 drawn and put into the bank, and that is reflected
23 in the -- what we submitted for your consideration,
24 the letter from our bank, from City Bank -- "City"

1 with a y -- dated May 16th showing that we have over
2 27 million in cash.

3 And, again, we certainly appreciate that --
4 you know, we had previously provided certain
5 unaudited numbers that could not have that sort of
6 third-party validation, so we certainly appreciated
7 that concern and have now provided this bank letter.

8 CHAIRWOMAN OLSON: Mike, if I'm correct --
9 I'm sorry. I don't want to interrupt you.

10 But that means that Criterion 1120.120 has
11 been met?

12 MR. CONSTANTINO: Well, my concern with the
13 letter, Kath, it says over a number of accounts,
14 "aggregate deposit balance of these accounts."

15 They have other facilities out there that
16 they're operating -- you know, I -- I had asked for
17 financial ratio information. I didn't think they
18 met the waiver. That's why I asked for it on two
19 different occasions, and they never provided it, and
20 then they provided this letter dated May 16th, 2016.

21 I don't know where the 59 million is coming
22 from. I never -- I haven't seen anything on that.

23 MR. SILBERMAN: If I may approach that.

24 This is being entirely cash-financed through

1 funds that the company has. Where is the disconnect
2 I believe -- and Mike will correct me if I'm wrong.
3 In the audited financials it shows -- I think it was
4 somewhere between 11- and \$14 million of cash on
5 hand, and there was some question with regards to a
6 debt that is no longer on the books, and that did
7 affect the cash utilization.

8 What we have supplemented in the letter in
9 May that showed the \$23 million in cash -- or excuse
10 me, the 27 million in cash -- is money that has been
11 identified for funding of this project, that the
12 cash on hand is viable to finance this project in
13 its entirety.

14 Now, what Dr. Kresch has addressed -- and he
15 will point out -- is -- and this, I think, goes to
16 Mike's concern if there's other projects, other --

17 DR. KRESCH: So in reference to the
18 statement by the banker that it's in a number of
19 accounts, we keep, at any given time, a lot of money
20 in the bank. The funds that are currently --
21 there's roughly 27-, \$30 million in the bank.

22 In order to -- the arrangement we had with
23 the bank -- in order to make sure that all of that
24 money is insured under FDIC insurance rules, the

1 banks have a system of dispersing and dividing up
2 the accounts and having multiple accounts, all of
3 which fall beneath the ceiling for coverage under
4 FDIC, so that by having the deposit in a number of
5 accounts divided up rather than a single account, we
6 have the protection of that money being insured by
7 FDIC should there be a problem.

8 CHAIRWOMAN OLSON: Seems like a good problem
9 to have.

10 MEMBER SEWELL: Is there any problem with
11 giving the staff the financial ratios they request?

12 MR. SILBERMAN: I --

13 MEMBER SEWELL: Because that would confine
14 it to this project.

15 MR. SILBERMAN: And I believe the answer is
16 we did, and that was in the supplemental material to
17 the staff report.

18 MR. CONSTANTINO: No. No. I need the
19 parent's financial ratio information. They're the
20 one funding this project, and that's what
21 I requested twice.

22 And we have a disagreement on whether they
23 met the waiver or not, and I didn't think they did
24 because I couldn't determine if they had sufficient

1 cash. And then I asked for the waiver -- or for the
2 financial ratios. That's required. And I haven't
3 received them.

4 MR. SILBERMAN: And I guess the response
5 would be that the Board's position has always been,
6 if a project is being financed entirely through
7 internal resources, that that qualifies for the
8 waiver of the financial viability ratios. And
9 I would hope that the Board would consider that, as
10 we have our CEO and our CFO here under oath -- that
11 they're both here and available to represent that
12 the cash available, internal funds, is on hand to
13 finance this project in its entirety. So --

14 MR. CONSTANTINO: When -- just a comment on
15 that.

16 When somebody tells us that they're going to
17 fund the project internally, we ask for the audited
18 financial statements. We look at cash and we look
19 at the funds restricted for construction. We do
20 that -- these are not-for-profits. For most
21 hospitals in the state they're not-for-profits.
22 That's what we look at. It's not just the cash
23 line.

24 Second, for-profit entities in the state --

1 which are essentially just two, Community Health
2 Service and UHS -- they are publicly traded
3 companies, and they send us their 10-Ks. I know
4 they have sufficient cash to fund the projects they
5 want to do in this state.

6 I don't know that from the information I've
7 looked at here, and that's why I didn't believe they
8 qualified for the waiver, and that's why I -- that's
9 why I requested the financial ratios.

10 CHAIRWOMAN OLSON: Go ahead.

11 MEMBER SEWELL: Not to change the subject
12 but -- turning to the unnecessary duplication of
13 services, do -- I guess I'd ask Mr. Constantino
14 this: Do we have a two-planning-area-versus-one-
15 planning-area situation here?

16 Is that where the problem is?

17 MR. CONSTANTINO: Yeah. We --

18 MEMBER SEWELL: They're basing their need
19 determination on combining two contiguous planning
20 areas?

21 MR. CONSTANTINO: That is correct. There is
22 a need in two contiguous areas, 29 beds where this
23 facility's going to be located and adjacent to
24 it is a 24-bed need for a total of a -- what is

1 that? -- 53.

2 And they're requesting a hundred.

3 MR. SILBERMAN: And --

4 MEMBER SEWELL: So a hundred would be okay
5 if we were allowed to do it based on two planning
6 areas?

7 MR. CONSTANTINO: That's correct. We have
8 to --

9 MEMBER SEWELL: But we're not?

10 MR. CONSTANTINO: No. That's correct.

11 MR. SILBERMAN: And the only thing is -- to
12 address that point -- because this was something we
13 understood in the design.

14 And if you note the geographic location,
15 this facility is proposed to be on Lake Cook Road.
16 Literally, the facility is on the edge of one
17 planning area and, if you walk across the street,
18 you're meeting a need. And to the concern that
19 Dr. Kresch raised in his opening comments, the
20 20-some bed needs isn't enough for a viable
21 facility.

22 And so, therefore, the question that we were
23 faced with and what this project is designed to do
24 is, instead of leaving two planning areas where

1 there's one unmet need, to propose one facility --
2 that we fully understand, by the Board's rules,
3 that, indeed, will be looked at by the one planning
4 area unless we could have found a way to build it
5 across Lake Cook Road, which wasn't going to be
6 realistic.

7 But what we hope is, in the discretion of
8 the Board, when you look at the overall need of the
9 area, when you look at the 45-minute drive time --
10 because that assessment does cross over the planning
11 areas -- and when you look at the overall need for
12 behavioral health services, that that will be
13 factored into the Board's decision.

14 MEMBER SEWELL: And we -- have we looked at
15 the occupancy issues in both planning areas?

16 I mean, it doesn't meet the criteria for the
17 one with respect to where all of the existing AMI
18 beds are and what their occupancy is, but what about
19 the other --

20 MR. CONSTANTINO: Yeah. We have a chart --

21 MEMBER SEWELL: -- what it says?

22 MR. CONSTANTINO: Go to page 21. There's
23 all acute mental health facilities within
24 45 minutes, and we have not identified an AMI

1 planning area. There's only one AMI planning area
2 or facility in A-08, which is where the 29 beds are
3 needed. That's Evanston Hospital and they're over
4 the threshold right now.

5 CHAIRWOMAN OLSON: So when you look at
6 Table 14, the first one on there, Chicago Behavioral
7 Hospital, and it's at 12.9 percent -- that's much
8 higher than that right now; right?

9 MR. SILBERMAN: Those are the most recent
10 available data that's reported.

11 CHAIRWOMAN OLSON: Right.

12 MR. SILBERMAN: But as we've reported --
13 Chicago Behavioral Health is the closest facility,
14 and it's currently turning patients away, that there
15 are times where they're at capacity. And Martina --

16 CHAIRWOMAN OLSON: You said 125 beds and
17 you're at a hundred-teens on a regular basis.

18 MS. SZE: The chart on Table 14 reflects
19 2014 data. We acquired that hospital in November,
20 so we are now at 125 beds and operating at
21 85 percent capacity.

22 CHAIRWOMAN OLSON: That's what I thought.

23 MR. KNIERY: Mr. Sewell, if I could address
24 your issues.

1 As you know, there are several indicators of
2 need. The staff has absolutely identified the
3 utilization rates of area facilities, and we
4 acknowledge that many of them are not at the State's
5 optimal capacity.

6 I would like to note -- point out, also, not
7 only does that 45-minute travel time show the two
8 planning areas but many more, many additional. But
9 there are many indicators of need, utilization rate
10 being one, the fact that -- you know, with all these
11 underutilized hospitals -- that, you know, we have
12 no opposition on the project from them. I think
13 it's significant.

14 That was -- you know, that's one of the --
15 the second indicator of need is a calculated bed
16 need. We have identified two areas that there is a
17 possible need for the service.

18 The third indicator is sufficient population
19 to support your project. In the two planning --
20 combined planning areas, A-08 and A-09, there's
21 1.2 million people. Within the 45-minute travel
22 contour, there's 5.9 million people, which kind of
23 brings us to the final indicator, is typically the
24 ratio of beds to population, and I would love to

1 have Martina just briefly address that for you.

2 MS. SZE: So when we look at markets, we
3 assess bed need by using a beds-per-100,000 ratio.
4 The national benchmark is 30 beds per 100,000 people.
5 the Illinois State average is 31 beds per
6 100,000 people.

7 At CBH, as we've noted, we've had to turn
8 away a lot of patients due to lack of bed
9 availability. So based on this experience, we
10 started planning for a new psychiatric hospital. We
11 looked at a number of areas, and the Northbrook
12 area, the planning area, stood out as having a
13 disproportionately low number of beds per
14 100,000 people. Right now there are only seven beds
15 per 100,000 people in the A-08 and A-09 areas. If
16 you approve our project, there will be still only
17 15 beds per 100,000 people, which is less than the
18 State average.

19 MEMBER GREIMAN: Chairman.

20 CHAIRWOMAN OLSON: Yes.

21 MEMBER GREIMAN: Yeah. I wanted to ask
22 Mike, what will make you comfortable to give you
23 what you need to work -- what will satisfy you?

24 MR. CONSTANTINO: I just want what we

1 requested.

2 MEMBER GALASSIE: Yeah. I'm in a position
3 where I -- if I may --

4 MEMBER GREIMAN: Yeah.

5 MEMBER GALASSIE: I'm very supportive of
6 this concept. Very much. And I know Lake County's
7 issues and needs. But I'm uncomfortable giving you
8 a yes vote without that financial information.

9 MR. SILBERMAN: If I could offer one thing
10 as an alternative consideration --

11 MEMBER GALASSIE: That's one vote.

12 MEMBER GREIMAN: That's right.

13 MR. SILBERMAN: -- which is, when we look at
14 other projects that are being looked at with regard
15 to debt financing, one of the things this Board has
16 raised is that people will come in with a commitment
17 of someone who is willing to consider the financing,
18 and this Board will approve these projects with the
19 understanding that "We're going to find someone who
20 will give us the money and we have confidence based
21 on our experience."

22 What we actually have in front of you is an
23 Applicant who's not asking you to have confidence
24 that they will find the money. They're standing

1 here before you under oath telling you that "We have
2 the cash to acquire the facility and to build it
3 out."

4 MEMBER GALASSIE: I'm going to apologize
5 because I'm interrupting you --

6 MR. SILBERMAN: Please.

7 MEMBER GALASSIE: -- but I have to tell you
8 I want to hear that from him, not from you, with all
9 due respect.

10 That's my level of confidence --

11 MR. SILBERMAN: That's my -- but if I --

12 MEMBER GALASSIE: -- speaking as a single
13 member.

14 MR. SILBERMAN: But if I understand
15 correctly -- and -- is -- what Mike is working from
16 is originally the audited financials, which are from
17 2015 and do give an accurate snapshot in time. But
18 the Applicant has then updated the information, but
19 it hasn't risen to the level of an additional round
20 of audited financials, and so -- you know, and -- if
21 you want to --

22 MR. KNIERY: I'd like to add, also, if
23 I may, Member Galassie, we did provide the entity's
24 ratios. And I'd love to even explore some of them,

1 if you wouldn't mind, if that would help you.

2 MEMBER GALASSIE: Sure.

3 MR. CONSTANTINO: Before John does that,
4 those are new entities -- okay? -- that -- and
5 they're not financing this project.

6 US HealthVest is financing the project, and
7 I don't think they meet the waiver requirements, and
8 all I'm asking for is the financial ratios for the
9 most -- we asked for three years. That's '13, '14,
10 and '15. That's what we asked for. I didn't think
11 they met -- I didn't think they met the waiver
12 requirements.

13 And now -- you know, they come in here now
14 and say they've got \$59 million. Well, I don't know
15 that. I haven't see any documentation of that.

16 And the comment about the letters we
17 received from people wanting to finance these
18 projects through a bank letter -- I don't accept
19 that. I never have. We've been negative on that
20 constantly before the Board. We will not accept a
21 letter of commitment made -- I just don't -- we
22 don't -- the staff -- the reports do not accept
23 that.

24 MR. SILBERMAN: And staff has been

1 consistent. I don't want to -- and, by the way,
2 this gives me one opportunity to clarify one
3 specific point, if I may.

4 There were some people who testified in the
5 public hearing that they had support that was not
6 accepted. What this actually was -- and I just want
7 to clarify this because I -- this is another example
8 where staff is absolutely right.

9 People had submitted referral letters where
10 they hadn't met all of the correct criteria, where
11 the letter was signed by the operations manager
12 instead of the physician, and so staff properly
13 rejected those referral letters. The testimony you
14 were hearing was from people who still cared enough
15 to come here and have their voice heard and show
16 their commitment.

17 So staff is absolutely right in its
18 rejection of those letters, and Michael is
19 consistent in his evaluation of the finances. What
20 we're trying to do is to point out that this Board
21 does have a degree of discretion in evaluating --
22 the real big-picture question is, "What is the
23 likelihood of this project to be successful
24 financially and operationally?" And --

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

2 MR. KNIERY: In discussing with our client,
3 I believe our client would be able to offer --
4 within, you know, a week's time -- documentation
5 from the investor group specifically to the extent
6 the funds are available for this project. You know,
7 we could do that as a condition to the permit,
8 however you foresee.

9 MR. MORADO: Are you referring to the
10 \$59 million number or --

11 MR. KNIERY: No. I'm talking specifically
12 about this project that -- you know, the money that
13 we are talking about that we do have. We can
14 provide you a specific signed affidavit, you know,
15 any -- what would fit?

16 MR. MORADO: So more than the letter you've
17 already given us to --

18 MR. SILBERMAN: So to have it certified so
19 that it's sworn to.

20 The idea being is this: We want the Board
21 and the staff to have the comfort that they want,
22 but our issue is that, at the end of the day,
23 there's a need for this care. The comments were
24 overwhelming.

1 I think to a point that John made is -- when
2 is the last time a project for a new hospital came
3 forward with zero opposition? And the reason is
4 because this is designed not only to meet an
5 existing need but to complement existing services.
6 There were no competitors who opposed, and many came
7 forward to support.

8 CHAIRWOMAN OLSON: Mr. Silber- -- Sewell.
9 Mr. Sewell.

10 MEMBER SEWELL: Why can't you just give Mike
11 what he asked for?

12 MR. SILBERMAN: The answer is, at this
13 point, because it would delay the consideration.

14 And if the answer was to provide the
15 guaranty in the process -- but the reasoning for why
16 it hadn't been provided previously was, very simply,
17 we had documented the cash available to finance the
18 project, which historically has been sufficient to
19 not require the financial.

20 And if I'm correct, what has been provided
21 is the ratios for the consolidated entities, but
22 what Mike is asking for is the ratios for the parent
23 company alone.

24 MR. CONSTANTINO: Yeah.

1 MEMBER SEWELL: Because that's the source of
2 the money.

3 MR. CONSTANTINO: Yeah.

4 MEMBER SEWELL: That's where the money's
5 coming from.

6 Okay. For me, as a member, I would want to
7 see the staff get exactly what they're requesting,
8 number one.

9 And, number two, I'd like to see what we've
10 been talking about today so that it -- regardless of
11 the fact that we technically cannot consider two
12 planning areas -- I don't really care about that
13 technicality -- but I'd like to see what it looks
14 like if you were dealing with two planning areas
15 with respect to these criteria that you did meet.
16 The bed need and the occupancy -- occupancy is sort
17 of there with this Table 14, but I'd like to see
18 that.

19 And then this Board would have to decide
20 whether they were going to, you know, consider that
21 instead of just the one planning area. I mean, do
22 we have any precedent for looking at more than one
23 planning area?

24 MR. CONSTANTINO: Not that I can recall,

1 Mr. Sewell, but we can do it if you want us to.

2 MEMBER SEWELL: But this Board has the
3 discretion to --

4 MR. CONSTANTINO: Oh, definitely, yeah.

5 MEMBER SEWELL: Yeah. I think, for
6 something like this category of beds and the way
7 that they are thinking more broadly about responding
8 to the need, I -- I personally would make an
9 exception to this one planning area. I don't know
10 how the other --

11 CHAIRWOMAN OLSON: I agree.

12 MEMBER SEWELL: -- members feel.

13 CHAIRWOMAN OLSON: I'm totally fine.

14 MEMBER SEWELL: But I want to see that.
15 I want to see what that looks like in relation to
16 bed need, in relation to occupancy, and then I want
17 to see the ratios that you're asking for.

18 CHAIRWOMAN OLSON: So let me ask -- let me
19 throw this out there just for -- if we amend the
20 motion to put a condition on it that -- within, you
21 said, seven days -- Mike can get the information
22 that he needs to be able to give us -- and I'm
23 actually kind of sorry I brought it up.

24 I thought -- the only reason I brought it up

1 was I thought it was met. I thought -- when we had
2 our conversation last week, I thought it was met.
3 But, to me, 27 million in the bank is good enough
4 but that's my opinion.

5 But I'm with you. I hate to see -- I mean,
6 this project is meeting a huge need. There is
7 absolutely no opposition. In fact, their
8 competitors were here supporting the project. So
9 I don't know -- I don't want to hold them up -- can
10 we put a condition on it -- help me out here, Juan.

11 MR. MORADO: Yes, we could place a condition
12 allowing the Applicant to provide us with the
13 requested information specifically with regard to
14 the financial ratios within -- I think you said
15 seven days. We might want to make it -- I don't
16 know -- 14.

17 MR. SILBERMAN: Whatever time frame we will
18 make happen.

19 MR. MORADO: So if that -- and -- like --
20 the condition would be that he would provide that
21 information that -- I mean, I guess what we have to
22 discuss -- is the condition going to be that they
23 just provide the information and, because we know
24 they have 27 million, we feel comfortable moving

1 forward or --

2 MR. SILBERMAN: We'd be prepared to offer up
3 both the ratios and the verification of the money so
4 that --

5 MR. MORADO: I think we have the
6 verification of the money with the letter.

7 MR. SILBERMAN: But I --

8 MR. MORADO: It's from their bank and they
9 said that here under oath.

10 CHAIRWOMAN OLSON: It's from their bank.
11 I don't know what --

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

13 MEMBER GALASSIE: But in addition to
14 submitting it, Mike has to agree with it.

15 CHAIRWOMAN OLSON: Mike doesn't have to
16 agree with -- I mean, the Board has -- and I -- with
17 all due respect to Mike -- I know he goes by the
18 book. But the Board has certainly agreed to grant a
19 CON where Mike didn't think that every single one of
20 these conditions was met.

21 I -- I don't know.

22 MR. MORADO: In terms of the condition, they
23 would just -- we would need to have a defined
24 time line and a defined action. If the defined

1 action is to provide the information within 14 days,
2 then that meets the requirements of the condition.

3 CHAIRWOMAN OLSON: Are people comfortable
4 with that or no?

5 MEMBER SEWELL: Sure. I am.

6 MR. SILBERMAN: And we would accept that
7 condition.

8 CHAIRWOMAN OLSON: Other questions?

9 MEMBER GALASSIE: I just -- I'm sorry.
10 I know it's late in the day. But I still think we
11 want Mike to review it and accept it as opposed to
12 their just submitting it. What if it isn't what it
13 should be?

14 MEMBER SEWELL: That's right.

15 CHAIRWOMAN OLSON: Well, then maybe they
16 have to come back at the next meeting.

17 MEMBER GREIMAN: Well, then they won't
18 have it.

19 MEMBER GALASSIE: Right. Then they won't
20 have it. I'm assuming they will.

21 MS. MITCHELL: It depends on the condition
22 that's placed on it.

23 CHAIRWOMAN OLSON: What would be the effect
24 to the project of waiting until our next meeting?

1 DR. KRESCH: The challenge for us from a
2 practical level is holding onto the real estate.
3 Landlords are not willing to keep buildings off the
4 market indefinitely.

5 And we've been able to hang on by giving
6 them a -- the landlord -- a proposed date for the
7 hearing. If it were postponed, I don't know that
8 they would be willing to -- if we'd lose our site,
9 it would be very difficult.

10 CHAIRWOMAN OLSON: So I guess we roll the
11 dice and take a vote. I don't know.

12 MEMBER GREIMAN: I think what I'd like to
13 know is specifically what Mike would be satisfied
14 with.

15 Can you tell us that? Then we can make that
16 decision.

17 MR. CONSTANTINO: Judge, I think we need
18 the financial ratios for the historic years for
19 US HealthVest.

20 And then Mr. Sewell had asked us to look at
21 it for two planning areas, AMI planning areas.
22 This -- and provide that to the Board. We can do
23 that.

24 MEMBER GREIMAN: That's different

1 conditions.

2 MR. SILBERMAN: And anyone in the room can
3 disagree with me, but I think -- Member Sewell, with
4 regards to the idea of looking at both planning
5 areas, I think that the one negative regarding need,
6 regarding the utilization of other area facilities
7 will hold true because it won't change that there
8 are other facilities. But the other components of
9 need regarding population per hundred thousand we've
10 already testified to and I think are already
11 factored in.

12 MEMBER SEWELL: I don't know if that
13 population -- that beds per hundred thousand
14 population is our standard.

15 MS. SZE: It is. It is.

16 MEMBER SEWELL: Is that our standard?

17 MR. CONSTANTINO: It --

18 MEMBER SEWELL: I mean, it is a standard
19 but --

20 MS. SZE: The calculation was based on the
21 State standard.

22 MEMBER SEWELL: On what our standard is?

23 MS. SZE: Yes. Correct.

24 MR. SILBERMAN: It's a different assessment

1 of need.

2 MEMBER SEWELL: Okay. Different way of
3 saying it.

4 MS. MITCHELL: If I may -- sorry to add to
5 this, but I just wanted -- so we're asking for the
6 historical ratios; right?

7 MR. CONSTANTINO: We asked for three years'
8 historic and then the projected years.

9 MS. MITCHELL: Okay. So if I'm
10 understanding this correctly, they just acquired
11 this new money. So are they -- so even if they
12 provide ratios to us, historical ratios to us, will
13 they be able to meet this?

14 It's -- am I --

15 MR. CONSTANTINO: They're not -- from my
16 review of what they've sent us, they're not going to
17 meet the margin percentage, right. I can tell you
18 that right now.

19 MS. MITCHELL: Based on historical
20 information; right?

21 MR. CONSTANTINO: Based on the information
22 they provided to me right now.

23 MS. MITCHELL: Right.

24 MR. CONSTANTINO: But that's not the

1 criteria. The criteria is the financial ratios for
2 the three historic years plus the projected years.

3 My feeling was they had not adequately
4 addressed that waiver, and we needed the financial
5 ratios.

6 MR. SILBERMAN: And the one irony in all of
7 this -- and I'll refer to our CFO.

8 But the one irony of all of this is, once
9 we've provided the financial ratios -- and we're
10 happy to if that's what the Board needs but -- we're
11 still financing this entirely by cash so -- but I'm
12 going to ask James, who knows this stuff better.

13 MR. CHA: Yeah. Just to clarify -- perhaps
14 this is already clear. But, you know, the
15 27 million that we show in the bank letter, that was
16 cash that we actually had in the bank as of May 16th,
17 you know. Based on our unaudited statements as of
18 May 31st, we have 28 million in cash, plus we still
19 have the 50 million that we have yet to draw because
20 that -- we just closed that financing last Friday.
21 We'll be putting out a press release probably
22 sometime this week, and we'll also be required to
23 file with the SEC a Form D, which will also be going
24 out within the next couple of weeks.

1 So we are a privately held company -- you
2 know, certainly I do appreciate Mike's concerns
3 regarding, you know, a certain lack of visibility
4 since we're not Universal, we're not Community. You
5 know, our financials are more closely held. You
6 know, we've -- we don't have, necessarily, the --
7 it's not normal practice to do sort of quarterly
8 audits or things of that nature.

9 So the audit that we have available, you
10 know, again, happens to be as of our fiscal
11 year-end, which is December 31. Subsequent to that
12 we did raise the 59 million, and certainly we have
13 documentation executed -- fully excluded
14 documentation regarding this \$50 million financing
15 that we just closed.

16 You know, I have it in my computer right
17 now, and certainly if -- insofar as that was useful
18 information or documentation that we could provide,
19 we could certainly do that, as well.

20 MR. MORADO: Is it fair to say that the
21 historical data will reflect that you're not going
22 to be in conformance with this criteria?

23 And that you are able to, today, show us
24 that you have a letter here for the 27 million

1 that's available for this project and that perhaps
2 the Board could consider it as a negative on the
3 State Board staff report but we have additional
4 information which they can take for -- take it for
5 what it's worth and vote on it that way?

6 MR. KNIERY: That would be fair. I would
7 like to add one point.

8 It's not that we're trying to hide anything.
9 We did provide the statements -- all the audited
10 statements -- that those ratios then have to be
11 calculated from. So you have that -- Mike has --
12 Mr. Constantino has that information. We do have to
13 go back and provide the ratios.

14 MR. MORADO: But when we receive it -- the
15 finding, it's not going to change.

16 MR. KNIERY: Right.

17 MR. SILBERMAN: The math will be the math.

18 MR. MORADO: The math will be exactly the
19 same.

20 MR. KNIERY: That's what I was saying.

21 MR. MORADO: You will be coming in before
22 us, and you'll say, "I know it says negative just
23 like it said last time, but here we have an
24 affidavit now versus a letter that says we have

1 \$27 million" --

2 MR. KNIERY: Right.

3 MR. MORADO: -- "that's in there to date."

4 CHAIRWOMAN OLSON: Are you ready to vote?

5 MR. SILBERMAN: Is there a condition being
6 added to -- attached to the --

7 CHAIRWOMAN OLSON: No.

8 MEMBER GALASSIE: Yeah, I believe there is.

9 I could vote aye with the condition that
10 they have to submit this information, financial
11 information, to Mike within two weeks.

12 CHAIRWOMAN OLSON: Okay. So did you -- but
13 what they just said is they can submit the financial
14 ratios but it's still going to be a negative
15 finding. It's not going to change.

16 What they're using for the financing is the
17 27 million and the 59 million that they've raised
18 since they -- the historical -- the historical
19 financial ratios are not going to change the
20 findings, is what they're saying.

21 So I don't know --

22 MR. MORADO: But I think, because
23 Mr. Constantino's asking for it, we should have the
24 Applicant provide that information along with -- it

1 seems like an affidavit might be a little stronger
2 than a letter.

3 MR. SILBERMAN: That's why -- what I was
4 suggesting. We're happy to provide both the
5 historical ratios that Mike has asked for as well as
6 to update the letter to a certification or
7 verification.

8 CHAIRWOMAN OLSON: Okay. So what you just
9 said will be the condition.

10 MR. SILBERMAN: And, for the record, we'll
11 agree to it --

12 CHAIRWOMAN OLSON: Yes.

13 MR. SILBERMAN: -- if that's required under
14 the rule.

15 CHAIRWOMAN OLSON: Is that all right?

16 MEMBER GALASSIE: Works for me.

17 MEMBER SEWELL: And we want to see the
18 two-planning area scenario.

19 CHAIRWOMAN OLSON: I thought we were going
20 based on the population ratios on that. We still
21 need to see something else?

22 MEMBER SEWELL: Well, but there's two
23 things. Isn't that correct?

24 There's the beds and the ratio will take

1 care of that. There's occupancy, too.

2 MR. CONSTANTINO: Yeah. We were just -- we
3 had requested the financial ratios, and it appears
4 they've come to -- the Board has come to a
5 resolution on that.

6 And then you suggest -- you had requested
7 that we look at the two planning areas, AMI planning
8 areas up there, and look at the beds. And we were
9 going to do that and provide that information to
10 you.

11 MEMBER SEWELL: Yeah. But you --

12 CHAIRWOMAN OLSON: But that's different than
13 on Table 14.

14 MR. SILBERMAN: No. That's, I believe, the
15 same.

16 CHAIRWOMAN OLSON: Is that what's on
17 Table 14?

18 MR. CONSTANTINO: Table 14 will show the
19 occupancy, but I believe -- and I -- maybe I'm wrong
20 on this.

21 But if you look on page -- we had put
22 together how we projected the beds for the one
23 planning area on page 6 of the report, A-08 AMI
24 planning area. And we were going to provide that

1 information to Mr. Sewell, how that is calculated.

2 MR. SILBERMAN: But I guess that -- we
3 aren't challenging that. If I'm correct, you also
4 provided that information to calculate the need
5 for -- that's how the need for A-9 was also
6 calculated. And if I'm correct --

7 MR. CONSTANTINO: Well, that's not presented
8 here, maybe. That's what I thought Mr. Sewell was
9 wanting us to do.

10 MR. SILBERMAN: But on page 21 it does have
11 the utilization of the two AMI services available in
12 A-9, A-09, the Highland Park Hospital and Vista
13 Medical Center.

14 MEMBER SEWELL: Okay.

15 CHAIRWOMAN OLSON: So the condition is that
16 they will supply -- we will get the financial ratios
17 for the three years and some documentation for --

18 MR. MORADO: And an affidavit attesting to
19 the fact that there is, in fact, \$27,326,184 -- at
20 least that much -- in the bank.

21 MR. SILBERMAN: In 14 days?

22 MR. MORADO: Within 14 days of this date, if
23 it's approved.

24 CHAIRWOMAN OLSON: Any other questions?

1 (No response.)

2 CHAIRWOMAN OLSON: I will call for a roll
3 call vote.

4 MR. ROATE: Thank you, Madam Chair.

5 Motion made by Mr. Johnson; seconded by
6 Mr. Sewell.

7 Mr. Galassie.

8 MEMBER GALASSIE: Aye, based upon
9 discussion.

10 MR. ROATE: Justice Greiman.

11 MEMBER GREIMAN: Aye, based upon the
12 agreement of the Applicant.

13 MR. ROATE: Thank you.

14 Mr. Johnson.

15 MEMBER JOHNSON: Yes, based on the
16 discussion and the subsequent conditions.

17 MR. ROATE: Thank you.

18 Mr. McGlasson.

19 MEMBER MC GLASSON: Yes, based on the
20 testimony this morning that indicated there's a need
21 if not a really urgent need.

22 CHAIRWOMAN OLSON: Thank you.

23 Mr. Sewell.

24 MEMBER SEWELL: Yes, for reasons stated.

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MR. ROATE: Madam Chair.

CHAIRWOMAN OLSON: Yes, for reasons stated.

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

CHAIRWOMAN OLSON: The motion passes.
Congratulations.

MR. SILBERMAN: Thank you very much.

DR. KRESCH: Thank you very much.

CHAIRWOMAN OLSON: Good luck.

- - -

1 CHAIRWOMAN OLSON: Okay. Next we have
2 Project 16-012, Transitional Care of Lake County.

3 May I have a motion to approve
4 Project 16-012, Transitional Care of Lake County, to
5 establish a 185-bed long-term care facility.

6 MEMBER GALASSIE: So moved.

7 CHAIRWOMAN OLSON: Thank you.

8 And a second, please.

9 MEMBER SEWELL: Second.

10 CHAIRWOMAN OLSON: The Applicant can come to
11 the table and be sworn in.

12 THE COURT REPORTER: Would you raise your
13 right hands, please.

14 (Four witnesses sworn.)

15 THE COURT REPORTER: Thank you. Please
16 print your names.

17 CHAIRWOMAN OLSON: Mr. Constantino, your
18 report.

19 MR. CONSTANTINO: The Applicants are
20 proposing to establish a 185-bed skilled nursing
21 facility in Mundelein, Illinois. The cost of the
22 project is \$29.3 million. The anticipated
23 completion date is June 30th, 2019.

24 There was no public hearing and there were

1 no opposition letters received. 65 letters of
2 support were in the application for permit. We did
3 have findings on this project.

4 Thank you, Madam Chairwoman.

5 CHAIRWOMAN OLSON: Thank you.

6 Comments for the Board?

7 They're sworn?

8 MR. SHEETS: Good afternoon.

9 Charles Sheets, again, on behalf of the
10 Applicants here.

11 I have with me Mr. Bradley Haber and
12 Mr. Brian Cloch, who are the managing partners of
13 the Applicant, and Anne Cooper from my office.

14 And I'll hand the microphone over to
15 Mr. Haber to present.

16 MR. CLOCH: My name is Brian Cloch, and I'm
17 one of the principals and cofounders of Innovative
18 Health. First, I'd like to thank the staff for
19 preparing such a thorough report and the opportunity
20 to respond to it.

21 Thank you, also, to the Board. We
22 appreciate the time you've --

23 THE COURT REPORTER: Excuse me. Could you
24 speak more clearly or more slowly? Either one.

1 MR. CLOCH: Yeah. No problem.

2 Thank you, also, to the Board. We
3 appreciate the time it takes for you to prep for
4 this meeting and be here today. Thank you also for
5 lending your expertise and volunteering your time to
6 ensure residents of Lake County have access to
7 quality skilled nursing care in a modern, state-of-
8 the-art facility.

9 Unlike the projects we presented to this
10 Board at the last meeting, the relocation of
11 Winchester House is the type of skilled nursing
12 facility project the Board typically considers. The
13 proposed project will offer custodial long-term
14 care, specialized memory care, as well as a
15 transitional care section that is -- as we discussed
16 at length last meeting.

17 It is also different than most proposals in
18 that it is a replacement proposal. We're replacing
19 an aging and deteriorating facility that is
20 approximately 170 years old that no longer
21 efficiently or effectively serves the needs of
22 Lake County residents. In the process, we are
23 actually removing 39 beds from the Board's inventory
24 while improving quality and access in lowering

1 overall health care costs.

2 As a resident of Lake County, I'm personally
3 committed to doing what it is -- what's in the best
4 interests of my community. Given the opportunity,
5 I'm particularly delighted to provide state-of-the-
6 art senior housing and skilled nursing care this
7 time to my neighbors.

8 Before we go into the details of the
9 project, my partner Brad with Innovative Health will
10 address some of the financial concerns highlighted
11 in the staff report.

12 MR. HABER: Thanks, Brian.

13 As mentioned, my name is Brad Haber, B-r-a-d
14 H-a-b-e-r. I'm a principal and cofounder of
15 Innovative Health. I'd also like to thank the Board
16 and Mr. Constantino for preparing such a thoughtful
17 and detailed report regarding Transitional Care of
18 Lake County.

19 Realizing the Board has extensive experience
20 within health care and financial reporting, I've
21 attempted to address all the financial concerns
22 raised in the staff report in the most efficient
23 manner as possible.

24 With regard to availability of funds, as you

1 may recall, the same team sitting up here today was
2 in front of this Board at the May meeting, and we
3 had a fruitful conversation regarding commitment
4 letters and what can and cannot be obtained at this
5 point in the development process.

6 At that time I mentioned that I am the
7 former head of credit and underwriting for
8 GE Capital's health care finance division, a role
9 I held from 2002 through 2013, and I can attest that
10 at this stage of the development process a true
11 no-outs commitment from any financial institution
12 does not exist in the market today.

13 The last time we were in front of the Board,
14 the issue of a firm commitment was of obvious
15 concern from several Board members, and it was
16 suggested that a bank should provide a commitment
17 subject to just the CON approval. The truth is, for
18 a bank to provide that type of letter, we would be
19 required to provide the financial institution
20 everything that would be required to make the
21 project construction ready.

22 The major items on this list include but are
23 not limited to a recorded zoning ordinance
24 evidencing compliance for the to-be-built project,

1 which would be no less than about six months to
2 complete and in excess of a hundred thousand
3 dollars; completed architectural and engineering
4 permit-ready construction documents, which would
5 take about six months and cost in excess of
6 \$700,000.

7 The developer would need to buy the land
8 outright versus an option because it will be highly
9 unlikely a land seller would provide for an option
10 to acquire the land for the extended period of time
11 required to get the previously mentioned steps
12 completed prior to applying for the CON. The land
13 alone for this project is \$2 1/2 million.

14 Finally, assuming all the above was
15 completed and approved, any financial institution
16 will require the commitment fee to be paid at the
17 time the commitment letter is issued. Average
18 commitment fees for a project of this nature are
19 1 percent of the loan amount. That would equate to
20 approximately \$250,000 for this project.

21 Having said so, the answer to the question
22 of "Why can't a financial institution provide a
23 commitment letter subject to CON approval?" is it
24 would cost the Applicant upwards of nine months of

1 additional time and \$4 million of additional costs
2 before we could even come to the Board to be heard
3 and find out whether or not we'll be awarded a
4 certificate of need.

5 Clearly, that is not a prudent approach, and
6 because of this inherent constraint and with the
7 Board's concerns and requirements in mind, we have
8 been diligent in making sure we have pursued and
9 will procure the most cost-effective financing
10 available in today's market.

11 Moving on from that particular point, we are
12 also confident in the financial viability of the
13 project. The State Board has a set of financial
14 availability ratios that are extremely relevant
15 within the overall health care sector but are not
16 specific to subsets of the industry, including
17 skilled nursing. Financial ratios that are most
18 relevant to the nursing sector are percentage of
19 debt to total capitalization and debt service
20 coverage, with debt service coverage being most
21 critical as it demonstrates an organization's
22 operating efficiency and ability to meet current
23 debt obligations.

24 The Board has set one and a half times debt

1 service coverage as the standard, and, from my
2 experience, that's spot-on accurate, and our project
3 overwhelmingly exceeds that metric at close to
4 four times.

5 In terms of total capitalization, the Board
6 has set a less-than-50 percent standard, which is
7 applicable to the health care field as a whole.
8 When you separate out skilled nursing, the standard
9 within the industry is a target of less than
10 80 percent from a conventional financing source and
11 90 percent for HUD.

12 The staff report notes that we are well
13 below that level in our first stabilized year, which
14 is well within market standard guidelines and also
15 meets the most stringent of underwriting criteria.
16 I would also like to note that the Board staff
17 report indicates the proposed project is in
18 conformance with the criterion reasonableness of
19 financing arrangements, terms of debt financing, and
20 the reasonableness of project costs.

21 Days of cash is a ratio that is not analyzed
22 within the skilled nursing but, rather, a ratio that
23 is critical when discussing hospital operations.
24 From the perspective of a hospital, something in the

1 neighborhood of 180 days' cash on hand is an ideal
2 target. The Board's standard for days' cash on hand
3 is set at greater than 40 days, and our project is
4 essentially at that target level with 32 days in
5 Year 1.

6 Of all the viability ratios, cushion ratio
7 is not particularly relevant to skilled nursing, and
8 I can say that, in my experience as a lender for the
9 better part of my career, my lending colleagues and
10 I have never placed any value on cushion ratio as a
11 meaningful criteria as it relates to health care
12 financing. It is also important to note we are not
13 aware of any financial lending platform in today's
14 market that utilizes cushion ratio as part of their
15 underwriting and approval standards.

16 As Mr. Constantino notes in the report, a
17 cushion ratio is an indication that an entity has
18 sufficient cash to pay principal and interest
19 related to the loan. For a project such as this,
20 that particular trigger is debt service coverage,
21 and, as previously mentioned, we have four times
22 debt service coverage in Year 3, which would be
23 considered an A rating in terms of credit.

24 With that being said, from a financial

1 viability and statistical review, our project meets
2 all the criteria that active lenders and equity
3 investors would look for when evaluating potential
4 opportunities.

5 I'll now turn this over -- back over to
6 Brian.

7 MR. CLOCH: Thanks, Brad.

8 First of all, I want to thank you in advance
9 for giving this project due consideration. As
10 stated previously, today's project is unique because
11 it is a replacement facility where we're actually
12 reducing the existing bed inventory by 39 beds taken
13 out of circulation.

14 Plus it is unique because it not only
15 provided -- it not only will provide traditional
16 skilled nursing care, focused on the existing
17 current custodial and memory care clientele, but we
18 will also offer our signature transitional care for
19 short-term, acute rehab guests.

20 As you heard from Chairman Lawlor, the
21 current Winchester House enjoys a rich history of
22 providing care to the residents of Lake County for
23 well over a century. Through an extensive RFP
24 process and board review, the Lake County Board

1 chose the team in front of you today to help them
2 transition out of the business of health care while,
3 at the same time, providing ongoing, uninterrupted
4 care for current Winchester House residents and
5 increased access and quality in the future to Lake
6 County through privatization and innovation.

7 Clearly, operating according to today's
8 standards in a 60-year-old 200,000-square-foot
9 building, which is more than two times the proposed
10 Transitional Care of Lake County's size with less
11 amenities, to say the least, is not optimal. As
12 such, Brad and I could not be more thrilled about
13 bringing this improvement to Lake County and this
14 proposed project to fruition.

15 The ability to innovate and create a new,
16 state-of-the-art facility that will provide a new
17 home for the current residents of Winchester House
18 is very exciting not only for us but for all the
19 current Winchester House residents and their
20 families. Plus the new Winchester House will
21 address the future needs of Lake County residents,
22 as well, and be part of the transformational change
23 to the health care delivery system that is badly
24 needed.

1 The proposed Transitional Care of
2 Lake County will be built on the current Winchester
3 House's time-tested, firm foundation of a century of
4 caring; strong skilled nursing program; high-quality
5 rehab department; growing, specialized memory care
6 program; robust life-enrichment offerings; and an
7 extensive community involvement.

8 With the needs of the current Winchester
9 House residents at the forefront, this replacement
10 project will offer three distinct clinical focuses.
11 Each of these areas will operate separately from the
12 others. Only backroom functions, as the kitchen and
13 crew member employee lounge, will be shared.

14 The first focal area is the custodial care
15 neighborhood for residents who are no longer able to
16 live on their own and require long-term care.

17 The second is a memory care community that
18 is designed specifically to meet the special needs
19 of people who suffer from dementia related to
20 Alzheimer's disease or other neurological illnesses.

21 And the third is the transitional care for
22 people who require specialized short-term care.

23 Similar to our other projects you have previously
24 approved, transitional care is a successful model

1 that is growing across the country. It addresses
2 the long-standing, untapped need to reform
3 short-term rehabilitative care.

4 This project has received no opposition and
5 overwhelming support, as evidenced by the fact that
6 over 65 letters were sent in favor for this project
7 from Lake County residents. We have also presented
8 letters of support from Congressman Robert Dold,
9 State Senator Carol Sente, State Representative
10 Ed Sullivan, and Mundelein Mayor Steve Lentz.

11 Comments along the way have included "It can
12 be very stressful having a loved one in a skilled
13 nursing or short-term rehab facility, but having one
14 of this caliber will definitely make my family
15 members feel more secure and improve the spirits of
16 the patients.

17 "As a Lake County taxpayer and someone who
18 worked with the Lake County system for over
19 30 years, this is good for Lake County. It's good
20 for the residents that are currently in that
21 facility, and it's good for people in the future
22 that will be taking advantage of these services. So
23 it's a win-win, in my opinion, that's been long
24 overdue."

1 In addition, the project concept is
2 supported by the Lake County Board throughout the
3 RFP process. As you probably recall, we were in
4 front of this -- we were in front of you this past
5 November where we were approved for the first phase
6 of the project, our change of ownership to operate
7 the current existing County facility.

8 We were extremely proud of the innovation we
9 have been able to bring to the Chicago area
10 heretofore, and we are now excited about bringing
11 that level of passion, innovation, and expertise to
12 Lake County to meet our current Winchester House
13 residents' needs and the future needs of the growing
14 and aging Lake County population.

15 With your support, we look forward to
16 continuing the Winchester House tradition with -- of
17 providing compassionate, quality health care while
18 bringing new innovation in resident-centered senior
19 care to Lake County with the replacement of this
20 important community asset.

21 Thank you for allowing us the opportunity to
22 innovate and help with the transformational change
23 in the health care delivery system in Illinois.

24 CHAIRWOMAN OLSON: Thank you.

1 Questions from Board members?

2 (No response.)

3 CHAIRWOMAN OLSON: Seeing none, I'll call
4 for a roll call vote.

5 MR. ROATE: Thank you, Madam Chair.

6 Motion made by Mr. Galassie; seconded by
7 Mr. Sewell.

8 Mr. Galassie.

9 MEMBER GALASSIE: I am very happy to
10 vote aye.

11 MR. ROATE: Thank you.

12 MEMBER GALASSIE: I've been disgusted for
13 the last 25 years.

14 MR. ROATE: Justice Greiman.

15 MEMBER GREIMAN: Aye. Aye.

16 MR. ROATE: Okay. Thank you.

17 Mr. Johnson.

18 MEMBER JOHNSON: I'm going to vote no based
19 on the State report. I still don't -- even based on
20 the testimony, I didn't really hear verification
21 based on the unnecessary duplication of services, so
22 I'm going to vote no.

23 MR. ROATE: Thank you.

24 Mr. McGlasson.

1 MEMBER MC GLASSON: Yes, based on testimony.

2 MR. ROATE: Thank you.

3 Mr. Sewell.

4 MEMBER SEWELL: I'm voting yes because it
5 looks like they had more beds and they're replacing
6 them with less beds in an area that does have excess
7 capacity.

8 So I'm okay with that.

9 MR. ROATE: Thank you.

10 Madam Chair.

11 CHAIRWOMAN OLSON: I vote yes for reasons
12 stated.

13 MR. ROATE: Thank you.

14 That's 5 votes in the affirmative; 1 vote in
15 the negative.

16 CHAIRWOMAN OLSON: Motion passes.

17 Congratulations.

18 MR. HABER: Thank you very much.

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1 CHAIRWOMAN OLSON: Next up we have
2 Project 16-014, St. Clara's Manor.

3 May I have a motion to approve Project
4 16-014, St. Clara's Manor, to establish a 140-bed
5 long-term care facility.

6 MEMBER GALASSIE: So moved.

7 CHAIRWOMAN OLSON: I need a second.

8 MEMBER MC GLASSON: Second.

9 CHAIRWOMAN OLSON: Thank you.

10 THE COURT REPORTER: Would you raise your
11 right hands, please.

12 (Five witnesses sworn.)

13 THE COURT REPORTER: Thank you. Please
14 print your names.

15 CHAIRWOMAN OLSON: Mr. Constantino, your
16 report.

17 MR. CONSTANTINO: The Applicants are
18 proposing to establish a 106-bed skilled nursing
19 facility in Lincoln, Illinois. The cost of the
20 project is approximately \$20.6 million. The
21 anticipated completion date is January 31st, 2018.

22 There was no public hearing, no opposition
23 letters received. We did have findings. And if you
24 would turn to page 3 under "Availability of Funds,"

1 where it says "Hickory Point Bank & Trust," that
2 should read "State Bank of Lincoln." The bank was
3 changed after I had written this report, and
4 I forgot to change the bank in the report.

5 CHAIRWOMAN OLSON: Thank you, Mr. Constantino.

6 MR. CONSTANTINO: It still wasn't a firm
7 commitment, though. The finding remains unchanged.

8 CHAIRWOMAN OLSON: Comments for the Board?

9 MR. HART: Good afternoon, Madam Chair and
10 Board members.

11 My name is Ben Hart. I'm president and CFO
12 of Heritage Enterprises. We're the management
13 company for the Applicant, and I'd just like to
14 introduce the people here at the table with me
15 today.

16 On my right, of course, is our CON
17 consultant, Mr. Kniery. On the far left is Mike
18 Blake, who is our senior vice president of
19 facilities. Next to him is David Underwood, our
20 chief financial officer. And finally is Mr. Clyde
21 Reynolds, who is president of the board of
22 St. Clara's Manor, Inc., as well as St. Clara's
23 Senior Services.

24 I'm going to turn it over to Mr. Reynolds.

1 MR. REYNOLDS: Good afternoon. This is my
2 first time here.

3 I did want to make a clarification. We are
4 a 140-bed facility now. We're actually wanting to
5 downsize to 106 beds. So whoever made the motion,
6 maybe they want to amend that.

7 But I wanted to say it's a pleasure to be
8 here. I want to thank you all for your efforts and
9 time on our behalf.

10 So the project we're proposing is similar to
11 a lot of the things of what Lake County said. We
12 are -- started life, actually, 130 years ago as a
13 hospital in the Logan County area. We performed a
14 function there, critical needs and capacity there
15 until the '60s.

16 In 1954 the community built a new hospital,
17 and ultimately that led to the -- they didn't need
18 two hospitals, and the old St. Clara's facility was
19 losing its accreditation because of its age and
20 stature. And so in 1962 the St. Clara's Hospital
21 ceased to exist, and the St. Clara's organization
22 went into hiatus.

23 The following year the St. Clara's Auxiliary
24 came out and formed St. Clara's Manor, Inc. It's a

1 not-for-profit, nondenominational organization with
2 the sole mission of providing facilities for the
3 aged, long-care facilities for the aged. In 1973
4 St. Clara's Manor arose out of the ashes of what had
5 been St. Clara's Hospital. It had provided a
6 service to area residents then, and just six years
7 ago, in 2010, we purchased 20 acres of land out on
8 the west end of town and we built a 52-unit
9 supported-living facility.

10 Just sort of a side note, we built that
11 facility next to a 50-acre tract where Abraham
12 Lincoln Memorial Hospital just built their new
13 facility, so our SLF is located right next to the
14 new hospital.

15 But St. Clara's Manor itself now faces a
16 crossroads. We're once again in an aged facility.
17 We're landlocked. We're downtown. We're a
18 two-story building. It's built in the institutional
19 style of the '60s and '70s that you would never do
20 today, and it's not as good a facility as other
21 facilities that are being built today.

22 So we could certainly invest in this
23 building and try and restore it and bring it up to
24 better standards, but we'll still be landlocked;

1 we'll still be an institutional-style building;
2 we'll still be downtown. And the alternative is to
3 go out and build a new facility on the edge of town,
4 on the same campus where Castle Manor is located.

5 Now, the Review Board evaluated our
6 application as if we were establishing a new
7 facility because the rules and regs won't let them
8 consider us as a relocation, but that's a real
9 critical distinction. We're not bringing any new
10 beds to Logan County. We're actually retiring
11 34 beds. The new community will be smaller than the
12 existing.

13 Moreover, the new community is going to
14 be -- instead of having the institutional feel of
15 the current St. Clara's, it's going to have five
16 home-style subdivisions within the single one-story
17 building; it's going to have -- 87 percent of our
18 beds are going to be private beds as opposed to
19 semiprivate. We're going to have two specialized
20 rooms for geriatric care. We're going to have
21 short-term -- specialized levels of care for
22 short-term care and rehab care. And we're going to
23 have indoor therapy, outdoor therapy, court -- we
24 have all these services we just can't do where we

1 are now. So, you know, the last thing will sort of
2 allow us to coordinate the services between Castle
3 Manor and St. Clara's Manor out on the same campus.

4 That's a lot of change. There are some
5 things that aren't going to change. In the end of
6 2015, over 64 percent of St. Clara's residents were
7 receiving Medicaid payments and just 42 percent of
8 Castle Manor's were residents of Medicaid. We plan
9 to continue that service.

10 We will also have the same staff that the
11 residents have known and worked with and have a
12 comfort level with, and so that sense of homeliness
13 or at least community will continue.

14 I have tried to be brief here, but I don't
15 mean to gloss over anything. If people have
16 questions, I will be happy to try and answer them.

17 MEMBER SEWELL: Madam Chairman.

18 CHAIRWOMAN OLSON: Mr. Sewell.

19 MEMBER SEWELL: Yeah.

20 Mr. Constantino, I wanted to -- what more do
21 you need on this availability-of-funds issue.

22 It looks like they have these tax-exempt
23 bonds in two categories for a little less than the
24 total cost of the project.

1 MR. CONSTANTINO: Yeah. The letter -- it's
2 not a firm commitment that they are going to get the
3 financing. The letter stated it wasn't a firm
4 commitment. That's what I'm looking for.

5 MEMBER SEWELL: Can they get any more than
6 this at that stage?

7 MR. CONSTANTINO: You'll have to ask them.

8 CHAIRWOMAN OLSON: Can we go back to the
9 comments that were just made?

10 MR. KNIERY: Yeah. I'd like to first
11 address it in terms of -- we are looking for -- it's
12 not traditional financing, conventional financing.
13 It is bond financing with a traditional construction
14 loan.

15 Mr. Underwood, if you'd like to take it and
16 address it a little bit further.

17 MR. UNDERWOOD: Thank you, John.

18 In reality, the gentleman that was here
19 prior to us that discussed credit limitations really
20 kind of spelled it out as well as I possibly could.
21 But the signed letter that we did get from the
22 financial institution basically uses approval of
23 this project as one of their criteria plus a -- they
24 also indicated that there's final due diligence,

1 which is always the case right before they go ahead
2 and actually issue the money.

3 So whether it's conventional financing or
4 bond financing or -- the letter from -- the
5 commitment letter at this point in time from the
6 lender is about as good as we could possibly expect
7 to receive at this juncture.

8 But I've spoken with the lender on numerous
9 occasions. This current lender also provides
10 depository services currently for St. Clara Manor
11 and St. Clara Senior Services so -- they're Lincoln
12 based. We're very familiar with them and very
13 confident that they will follow through on their
14 commitment as stated in the letter that was earlier
15 distributed to the staff.

16 CHAIRWOMAN OLSON: Other questions?

17 (No response.)

18 CHAIRWOMAN OLSON: I just want to make sure
19 I have my numbers right here.

20 You're closing the current 140-bed facility
21 and building a 106-bed facility?

22 MR. KNIERY: Correct.

23 CHAIRWOMAN OLSON: So while there's a
24 97-bed excess in the planning area, you're decreasing

1 by 36 beds.

2 And then if you could look at Table 1 on
3 page 5 in the State Board staff report, it looks
4 here like, with the exception of the swing beds at
5 Lincoln Hospital, that Christian Nursing Home is the
6 only other nursing home in Lincoln.

7 MR. HART: There are actually two other
8 facilities in --

9 CHAIRWOMAN OLSON: Oh, yeah. I -- well,
10 outside --

11 MR. HART: -- Symphony as well as Christian
12 Nursing Home.

13 CHAIRWOMAN OLSON: And if you take out the
14 0 percent utilization in those swing beds, according
15 to my math, it comes up to over 70 percent
16 utilization in those current spaces combined, so
17 you're running out of beds.

18 MR. KNIERY: You're absolutely right. If we
19 were to discontinue even the number of beds to
20 create a zero net need, there's not enough places in
21 Lincoln to take care -- there's not enough beds in
22 Lincoln to take care of people.

23 CHAIRWOMAN OLSON: That will be displaced by
24 those?

1 MR. KNIERY: That's exactly right. And just
2 one additional point I think is very important.

3 Your rules require 30- and 45-minute travel
4 time, and I'm not contesting any of that. But what
5 is interesting is, looking at their patient origin,
6 96 percent of all residents in-house come from one
7 single zip code, the city of Lincoln.

8 CHAIRWOMAN OLSON: Okay. Coming from a
9 small community, I understand that.

10 MR. KNIERY: Yeah.

11 CHAIRWOMAN OLSON: Other questions or
12 comments?

13 (No response.)

14 CHAIRWOMAN OLSON: Seeing none, I'd ask for
15 a roll call vote.

16 MR. ROATE: Thank you Madam Chair.

17 Motion made by Mr. Galassie; seconded by
18 Mr. McGlasson.

19 Mr. Galassie.

20 MEMBER GALASSIE: Aye. Based on discussion.

21 MR. ROATE: Aye? Thank you.

22 Justice Greiman.

23 MEMBER GREIMAN: Aye.

24 MR. ROATE: Thank you.

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Mr. Johnson.

MEMBER JOHNSON: Yes, based on the
discussion we just had.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on need.

MR. ROATE: Thank you.

Mr. Sewell.

MEMBER SEWELL: Yes, based on discussion.

MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: Yes, based on the need in
Lincoln.

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

CHAIRWOMAN OLSON: The motion passes.

Congratulations and good luck.

MR. KNIERY: Thank you very much.

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1 CHAIRWOMAN OLSON: Next, we have -- that
2 actually ends our applications subsequent to initial
3 review. We have one application subsequent to
4 intent to intend, Project 15-044, Transformative
5 Health of Mercy.

6 Oh, I'm sorry. Of McHenry.

7 MR. CONSTANTINO: Madam Chair, the
8 Applicants have a presentation, and they provided
9 the Board with a handout here. We'd like to
10 distribute it. You've already seen it. It's
11 already in your material. It would just be easier
12 for you to follow.

13 I've reviewed it. It's all material you've
14 seen before.

15 MS. AVERY: Okay.

16 MR. MORADO: That's fine.

17 CHAIRWOMAN OLSON: That's fine.

18 Okay. The Applicant will be sworn in.

19 THE COURT REPORTER: Raise your right hands,
20 please.

21 (Five witnesses sworn.)

22 THE COURT REPORTER: Thank you. And please
23 print your names.

24 CHAIRWOMAN OLSON: May I have a motion to

1 approve Project 15-044, Transformative Health of
2 McHenry, to establish a 98-bed long-term care
3 facility.

4 MEMBER JOHNSON: So moved.

5 CHAIRWOMAN OLSON: And a second, please.

6 MEMBER SEWELL: Second.

7 CHAIRWOMAN OLSON: Mr. Constantino, your
8 report.

9 MR. CONSTANTINO: One other thing. We
10 didn't pay for this nice handout.

11 CHAIRWOMAN OLSON: I'm sure you didn't.
12 I know we don't have any money.

13 MEMBER SEWELL: No, Mike, it doesn't look
14 like your work.

15 CHAIRWOMAN OLSON: Ouch.

16 Mr. Constantino, your report.

17 MR. CONSTANTINO: The Applicants are
18 proposing to construct and operate a 98-bed
19 long-term care facility in McHenry, Illinois. The
20 cost of the project is approximately \$19.3 million.
21 The anticipated completion date is December 31st,
22 2017.

23 There were findings on this project. This
24 project received an intent to deny at the February

1 2016 State Board meeting.

2 Thank you, Madam Chairwoman.

3 CHAIRWOMAN OLSON: Thank you, Mike.

4 Comments for the Board?

5 MR. CONSTANTINO: Excuse me a minute.

6 We did -- we do have two comments on the
7 State Board staff report. They're in front of you.
8 They were received timely.

9 CHAIRWOMAN OLSON: Thank you.

10 Comments?

11 MR. JENICH: Yes. Good afternoon, Madam
12 Chairwoman and respected members of the Board.

13 My name is Gerry Jenich -- that's G-e-r-r-y
14 J-e-n-i-c-h -- and I am the manager for the
15 Applicant, TCO JV, LLC, for Project No. 15-044,
16 Transformative Health of McHenry.

17 I'm pleased to have with me today
18 Mr. Dan Lawler, our CON counsel; Mr. Scott Higgs, a
19 certified public accountant and the senior vice
20 president of finance for the Main Street Property
21 Group and the co-Applicant MS McHenry; Mr. John
22 Kniery, our CON consultant.

23 And also available and present to answer any
24 additional questions you may have is Mr. Andy Van

1 Zee, representing MS McHenry, LLC, the co-Applicant
2 for this project. Not present but in our thoughts
3 today is Mr. Charles Foley, our CON consultant.

4 We are here before you today to respectfully
5 ask for your approval for the establishment of a
6 specialized 98-bed all-private room transitional
7 care facility to be named Transformative Health of
8 McHenry.

9 The skilled nursing project will provide
10 modernized transitional postacute health care
11 services in a purposeful, resident-centric facility
12 which has been designed to provide a unique and
13 significant role in the existing continuum of care.

14 There is an established bed need in McHenry
15 County planning service area for 127 additional
16 nursing home beds, which supports our request for a
17 98-bed skilled nursing facility to fill this need.

18 The Board considered our project at its
19 February 16th, 2016, meeting when it issued an
20 intent to deny. Since that time we have embraced
21 the opportunity to respond to the Board's concerns,
22 and we have provided additional documentation that
23 we believe thoroughly addresses the Board's
24 questions and fulfills any additional information

1 requests by the staff.

2 On behalf of our project team, I would like
3 to thank and recognize the staff for their work on
4 the State Board staff reports and for their patience
5 in participating in multiple technical assistance
6 meetings with us throughout this process. They've
7 been helpful, polite, timely in their responses, and
8 professional in performing their duties.

9 Thank you, all.

10 I'd like to ask Mr. Lawler to first address
11 the most recent State Board staff report findings
12 and our responses to the Board's two negative
13 findings. I will then follow up with an explanation
14 as to how this project is uniquely different from
15 existing providers and warrants your approval here
16 today.

17 Mr. Lawler.

18 MR. LAWLER: Thank you, Gerry.

19 Madam Chair and members of the Board, we're
20 before you following an intent to deny, and we were
21 hoping for a bit fuller Board attendance today.
22 Given that we need 5 of 6 available votes, we
23 seriously considered a deferral today but we're
24 proceeding today. We had a lot of public comment

1 show up today. We didn't want to send them home and
2 bring them back later if they were even available
3 later.

4 A deferral is also costly, but the main
5 reason we're seeking a vote today is that all of the
6 negative votes the last time we were up were based
7 on staff's negative findings on two criteria. And
8 if you will kindly bear with me today, I will show
9 that we meet the letter and intent of those two
10 criteria and seek your positive consideration.

11 As it stands, the staff report has 18 of
12 20 positives. I've been doing this for 30 years and
13 would take a report like that just about any day.
14 That's 90 percent positive and would get you an A on
15 most tests. I'd like to make the case today that we
16 should receive an A plus on this test.

17 The two negatives were on 1125.570, service
18 accessibility, and 1125.580, unnecessary
19 duplication, so I'll start with 570.

20 Mr. Constantino referred to my written
21 comment on the staff report -- that's the Barnes &
22 Thornburg letter dated June 13th -- and the service
23 accessibility criterion is included as Attachment 1.
24 You can see that, under paragraph A, there are five

1 listed factors -- five numbered factors -- and the
2 rule requires the Applicant to document at least one
3 of the factors in the planning area.

4 On page 13 of the staff report, the staff
5 also says that the Applicants must document at least
6 one of the factors exists in the planning area, then
7 page 16 of the staff report shows that we documented
8 at least one of the factors. We documented that
9 areas in McHenry County have been designated as
10 medically underserved populations, and we documented
11 that area facilities have restrictive admission
12 policies.

13 At this point you might think we were in
14 good shape. The rule requires at least one of five
15 factors exists in the planning area, and we
16 documented at least one exists in the planning area.
17 But I knew from past experience that this doesn't
18 always carry the day, so even before the staff
19 report was issued, I asked for a technical
20 assistance meeting to make the case that "at least
21 one" means "at least one" and does not mean
22 something other than "at least one."

23 I had supposed that, as an experienced
24 attorney with superior powers of persuasion, I would

1 knock this one out of the park on the first try and
2 convince everybody that "at least one" means "at
3 least one" and doesn't mean something else, but
4 I couldn't do it at the first technical assistance
5 meeting or the second. At the third meeting
6 I thought I was making headway, but as you can see
7 from the staff report, I struck out. I could not
8 convince your staff that "at least one" means "at
9 least one."

10 Page 15 of the staff report shows that the
11 staff is requiring documentation of one of the first
12 four factors plus the fifth factor. I respectfully
13 ask how can that interpretation be derived from the
14 rule's language that at least one factor be
15 documented.

16 Section 1125.570 is a duly promulgated
17 administrative regulation of this Board to which
18 certain legal principles apply that Justice Greiman
19 will be very familiar with. Administrative
20 regulations have the force and effect of law, and
21 they are interpreted according to the same rules of
22 construction that are applied to statutes. The
23 primary rule of statutory construction is to give
24 effect to the drafter's intent, and the best

1 indicator of legislative intent and agency intent is
2 the plain and ordinary language of a statute or rule
3 itself.

4 What could be more plain and ordinary than
5 the phrase "at least one"? The drafter of that
6 phrase, this Board, intended it to mean "at least
7 one of the five factors." It did not intend that
8 phrase to mean "one of the first four plus the
9 fifth" because that's not what the plain language of
10 the rule says.

11 One more legal principle on agency
12 regulations: When an agency has adopted a
13 regulation under its statutory authority, the agency
14 is bound by that rule as written and may not add
15 requirements to the plain language of the rule.

16 The staff here has added requirements that
17 are not in the plain language of the rule itself and
18 that's not right. Now, I know what the staff's
19 concern here is, and it is a very legitimate
20 concern. The staff is concerned about
21 underutilization in the planning area, and this
22 Board is rightly concerned about that, too.

23 The Board has a separate rule, 1125.580,
24 specifically addressing underutilization, and there

1 is no "at least one" language in that rule.

2 In that rule the Board specifically lays out
3 what it wants to see from an Applicant when
4 there are underutilized facilities in the planning
5 area, and there are no exceptions or caveats or
6 options in that rule. You meet it or you don't, and
7 if you don't, then you should get a negative. I'll
8 address that next because we got a negative there
9 even though we provided exactly what your rule asked
10 for when there is underutilization.

11 We meet the letter and intent of Section 570
12 and should have a positive finding there because we
13 documented at least one of the five factors on
14 service accessibility, and that is all that the rule
15 requires by its plain and ordinary language.

16 As the rule is written, underutilization
17 should not automatically trigger a negative, but
18 that is how the staff is interpreting it. We only
19 ask the Board to apply the rule as written, and if
20 it's applied as written, we satisfy the rule.

21 Before I leave Section 570, I want to
22 address some points that have been raised in
23 connection with the factors we documented, and
24 that's medically underserved population and

1 restrictive admission policies.

2 Some portions of the staff report might
3 leave the impression that medically underserved
4 populations are generally small geographic areas
5 with relatively few people in them, but that is
6 definitely not the case in McHenry County, and the
7 staff report does point that out. As the staff
8 report notes, over one-third of the geographic area
9 of McHenry County has been designated as a medically
10 underserved population. That's 200 square miles.
11 Also, over 80 percent of the County's population
12 reside in that area. That's over 25,000 people.

13 Under your rule, the size of a medically
14 underserved population doesn't matter, but even if
15 it did, the McHenry County planning area has a very
16 large medically underserved population in terms of
17 both geographic area and population.

18 Another point that has been raised is the
19 contention of our opponents that the proposed
20 project itself must be located inside the area
21 designated as medically underserved. That is not a
22 requirement of the rule. That is something that our
23 opponents made up.

24 The rule only requires that the planning

1 area in which the project is located have a
2 medically underserved population. The planning area
3 here is McHenry County. McHenry County has a large
4 medically underserved population, and our project is
5 located in McHenry County. That satisfies the
6 requirement of the rule as it's written.

7 Another requirement that our opponents made
8 up is that the proposed facility must be within
9 30 minutes of the area designated as medically
10 underserved. Note how they contradict themselves
11 here. On the one hand they say the rule requires
12 that the project must be located inside the
13 medically underserved area, then they make up a new
14 requirement and say that the rule requires the
15 project to be within 30 minutes' travel time of the
16 medically underserved area. Again, the rule does
17 not require the project to be located within
18 30 minutes, but even if it did, the record shows
19 that a very large portion of the medically
20 underserved population is within 30 minutes of our
21 proposed facility.

22 With regard to these requirements that our
23 opponents have made up and change at will and that
24 are not in the Board's rule, I would again point out

1 the legal requirement that, when an agency has
2 adopted a regulation under its statutory authority,
3 the agency is bound by it, as written, and may not
4 add requirements to the plain language of the
5 regulation. The staff can't add requirements.
6 Opponents can't add requirements. The rule, once
7 promulgated, has to be applied as written.

8 Regarding the second factor under 570, the
9 staff report notes that we documented restrictive
10 admission policies at two facilities in the planning
11 area, one of which does not accept Medicaid
12 patients.

13 We had sent the staff the facility's
14 Long-Term Care Facility Profile and said it showed a
15 facility had zero Medicaid patients in 2014, and
16 staff relied on that representation as the basis for
17 finding that Medicaid admissions were restricted at
18 that facility. Our opponents, who include the
19 facility that accepts no Medicaid, filed a response
20 to the staff report to dispute the staff's finding.
21 They claim that they do not have a restrictive
22 admission policy, that they do accept Medicaid
23 patients, and that 10 percent of the patients they
24 have are Medicaid patients.

1 I freaked out a little when I saw that. I'm
2 thinking, "Did we misrepresent something to
3 Mr. Constantino? Did we tell Mike the facility
4 profile showed zero Medicaid when it showed
5 10 percent? Did we not see the 1 in front of
6 the 0?"

7 So I immediately went to the 2014 profile,
8 which is on your website, to confirm what it
9 actually says and it says 0. There is no 1 in front
10 of the 0. It does not say "10 percent." It says
11 "0."

12 So now I'm wondering whether 2014 was an
13 off year for them. Maybe they had lots of Medicaid
14 patients in prior years. So I looked at all the
15 profiles I could find on your website, which went
16 back to 2011. For each and every year, this
17 facility reported its Medicaid patients as zero.
18 Not 10 percent, not even 1 percent, but 0, 0, 0, 0
19 for four straight years.

20 I knew that your old website had facility
21 profiles going back to 1995. I couldn't find them
22 on the new one, so I asked Mr. Kniery if he had them
23 and he did. In those 20 years, 1995 to 2014, this
24 facility's own profiles show that it has not

1 admitted a single Medicaid patient in all
2 those years. Now, that is a restrictive admission
3 policy.

4 And here's something most peculiar about our
5 opponents' response to the staff report: Regarding
6 our expectation of having a Medicaid payer mix at
7 least as comparable to area hospitals, which is
8 7.7 percent, our opponents say there is, quote, "no
9 way a facility like ours could reach that level,"
10 and they say it is, quote, "amazing to suggest that
11 we will."

12 Now, I can understand how a facility that
13 has not admitted a single Medicaid patient in the
14 last 20 years would think there is no way to serve
15 7.7 percent Medicaid and that it would be amazing to
16 suggest that anyone can, but these are the same
17 folks who are saying that they have 10 percent
18 Medicaid even though 20 years of their own facility
19 profiles show that they have never admitted even one
20 Medicaid patient. Now, that's an amazing thing for
21 somebody to suggest.

22 And even if they did admit Medicaid, though
23 they've never reported any in 20 years, we still
24 documented the factor of medically underserved

1 population, and your rule requires only that at
2 least one factor be documented. The staff agrees
3 that we documented that factor, and we should
4 receive a positive finding under 570.

5 Moving on to 1125.580, unnecessary
6 duplication, Section 580 is where the rules
7 specifically focus on underutilization and what the
8 Applicant can do about it. The criterion is
9 included as Attachment 2 to my response to the staff
10 report. The rule looks at historical utilization
11 and it looks at future utilization.

12 What is very important to note is that the
13 rule does not say that, if there is historical
14 utilization -- underutilization -- the Applicant is
15 out of luck and goes home empty-handed.

16 No. The rule says that, if there is
17 historical underutilization, the Applicant must
18 document something about future utilization, and the
19 rule is very specific about what must be documented.
20 There are two things.

21 First, if there are existing facilities that
22 are historically at or above target utilization, the
23 Applicant must document that the project will not
24 lower their utilization below target occupancy

1 within two years after project completion.

2 Second, if there are existing facilities
3 that are historically below target utilization, the
4 Applicant must document the project will not lower
5 to a further extent the utilization of those
6 facilities.

7 Note what is being said here. The drafter
8 of this rule, the Board, is recognizing that there
9 will always be underperformers and there is really
10 nothing the Board or the Applicant can do about
11 that. As to them, the rule is saying, "Just don't
12 make them any worse than they already are. Don't
13 reduce their utilization to a further extent."
14 That's what the rule says.

15 As for the strong performers who are at or
16 above target occupancy, the rule is saying, "You can
17 take them down to target occupancy but no more.
18 They are strong now and we want them to remain
19 strong in the future." That's a good rule. It
20 encourages good performance and it does not enable
21 underperformance.

22 And please note again the rule recognizes
23 that there are and always will be underutilized
24 facilities, and that, alone, does not trigger a

1 negative under this rule. The rule does not
2 penalize Applicants for underperformance of other
3 facilities, but the staff has punished us with a
4 negative finding solely because of these
5 historically underutilized facilities without regard
6 to the future utilization aspect of your rule.

7 The negative finding here enables
8 underutilization. It provides a positive incentive
9 for facilities to remain underutilized because they
10 know their underutilization will result in a
11 automatic negative finding from the staff on new
12 project applications. But the Board's rule, as
13 written, does not promote underutilization in this
14 way.

15 If the Applicant can document that its
16 proposed project will not reduce strong facilities
17 below target utilization and will not reduce the
18 underperforming ones lower than they already are,
19 then the letter and intent of the rule are satisfied
20 and the Applicant should receive a positive finding.
21 We have documented above and beyond what the rule
22 requires and should have a positive finding on this
23 criterion.

24 How does an Applicant document what the

1 utilization of the planning area will be two years
2 from project completion? There is only one way to
3 do that. You have to make projections. You have to
4 take existing historical data, come up with a
5 methodology, and then use the historical data and
6 methodology to make projections about the future.
7 There is no other way to do it, and the rule says
8 you have to do it.

9 Some Applicants just make up their own data
10 and their own methodology, and this is often looked
11 upon with suspicion because it's hardly objective
12 and often not reliable. Sometimes the Applicant
13 pays a professional consultant to make objections,
14 and their objectivity and reliability might also be
15 called into question.

16 We haven't relied on either of those
17 sources. We are relying on the most objective, most
18 reliable, most professional source imaginable. We
19 are relying on the State Board's own projections as
20 to what planning area utilization will be in the
21 future. Your projections are the foundation of the
22 CON planning process. Those projections must be
23 validated and must be reliable or else we wouldn't
24 have a legitimate planning process at all.

1 Now, there may be a tendency to think that,
2 if there is a projected bed need in an area with
3 underutilized facilities, then something must be
4 wrong. And since the historical data can't be
5 wrong, it must be the projections, but that's not
6 the case at all.

7 Historical underutilization and future bed
8 need can, in some circumstances, be entirely
9 consistent, and that's the situation here. Your
10 projections for McHenry County fully account for the
11 current, existing underutilization.

12 Let's look at those projections. They are
13 contained in Attachment 4 to my response to the
14 staff report, and that page is directly from the
15 inventory of health care services for long-term care
16 category of service.

17 There are 997 long-term beds, long-term care
18 beds in the planning area. Your latest inventory
19 shows that, of the nine long-term care facilities in
20 McHenry County, eight were underutilized, so that's
21 the starting point of your projections. Every
22 facility in the county but one is underutilized.
23 That's taken into account.

24 Now let's project into the future. The

1 first place to look is projected population growth.
2 The total population growth in McHenry County is not
3 all that much. As noted in the staff report, it's
4 only a little over 1 1/2 percent annually.

5 But the growth rate in the 65-and-over age
6 cohorts is very high. As noted in the staff report,
7 the five-year growth in the 65-to-74 population is
8 over 31 percent and the 75-and-over population is
9 over 25 percent. The aging of the population is
10 guaranteed. Nothing is going to stop the aging
11 process, try as we might.

12 Inevitable aging of the population would
13 create a tremendous demand for long-term care beds,
14 so much so that, despite the fact that eight of
15 nine existing facilities are currently underutilized
16 and despite the fact that these facilities currently
17 have 254 dead beds which they don't even set up, the
18 Board has determined that future demand will be so
19 great that, even with 90 percent occupancy of all
20 997 beds, there will still be a need for 127 more
21 beds, and that means there is a need for our
22 proposed 98-bed facility.

23 That's not our projection. That's not a
24 paid consultant's projection. That is the

1 projection of this Board and its professional staff
2 pursuant to the statutory mandate. The Planning Act
3 directs the Board to plan for and promote the
4 development of modern health care facilities,
5 especially in areas where the planning process has
6 identified unmet need. The Board's planning process
7 has identified an unmet need in McHenry County, and
8 this project will provide modern, comprehensive,
9 long-term care services to meet that need.

10 So we have gone above and beyond what your
11 rule requires. We have documented that the one
12 facility above target utilization will remain at
13 target utilization, and we have documented that
14 future demand will allow all the underutilized
15 facilities to not merely maintain their current
16 occupancy levels, which is all the rule requires,
17 but, also, reach target occupancy themselves, which
18 is far beyond what the rule requires.

19 Our opposition is saying that your
20 projections are off and that they will never be at
21 target utilization, but who's calling the shots
22 here? Is it the Board, who has the statutory
23 authority and obligation to make these projections?
24 Or is it the self-interested competitors who never

1 want to see a new, modern facility in McHenry
2 County?

3 And even if your projections are off some
4 and these facilities don't hit the target occupancy,
5 your rule does not require that they do. It only
6 requires that they maintain their current level of
7 utilization, and your projections amply demonstrate
8 at least that.

9 So with the most reliable, most objective,
10 most professional evidence out there, we have
11 documented complete compliance with your criteria,
12 and we should have a positive finding here.

13 There is an additional factor under 580
14 which strongly supports our project. Under 580 a
15 surplus of beds is indicated when the bed-to-
16 population ratio in the planning area exceeds
17 1 1/2 times the State average.

18 The bed-to-population ratio in McHenry
19 County is less than half the State average, which is
20 much less than 1 1/2 times the State average. The
21 bed-to-population ratio is so low in McHenry County
22 that, according to the Board's inventory, it has the
23 second lowest number of long-term beds per person
24 among all 95 statewide planning areas. It's so low

1 that, even with the addition of the 98 beds in this
2 project, McHenry County will still have the second
3 lowest bed-to-population ratio of all statewide
4 planning areas.

5 Page 19 of the staff report concludes that,
6 based on these ratios, it does not appear that there
7 is a surplus of long-term care beds in McHenry
8 County. Our opponents' spin on this finding of the
9 staff report is mind-boggling. In their response to
10 the report, our opponents cite the staff's finding
11 that there is no surplus of beds, then they say,
12 quote, "This translates to there is an excess of
13 beds."

14 I don't know what translation service our
15 opponents are using, but when the staff says there
16 is no surplus of beds, that does not mean there is a
17 surplus of beds. Maybe that's what it means in
18 Bizarro World, but in the real world, when the staff
19 says there is no surplus of beds in McHenry County,
20 it means there is no surplus of beds in McHenry
21 County.

22 One final point before I turn things back to
23 Mr. Jenich: You have heard our opponents say that
24 we are skimming the Medicare patients from area

1 hospitals. We have examined that claim by asking a
2 health care data provider that the Applicants rely
3 on in the ordinary course of business to provide the
4 data on referrals and admissions from the area
5 hospitals. That data they supplied to us shows that
6 area facilities admit only one-half -- about
7 one-half of the Medicare patients that are referred
8 to them. Of over 1600 Medicare patients referred to
9 these facilities in 2014, 860 were admitted and
10 780 were not.

11 That surprised us so we sought confirmation
12 from the hospitals themselves independently. We
13 sent the data to Centegra Hospitals and asked if it
14 was consistent with their experience, and they told
15 us that it was, and that was confirmed by the
16 Centegra executive who spoke this morning.

17 Why are so many patients in need of skilled
18 nursing services not being admitted to area
19 facilities? There are only two likely reasons for
20 that. Either the facility doesn't accept the
21 patient or the patients and their families don't
22 accept the facility.

23 In either case, neither is a good reason for
24 denying a new facility in McHenry County, but both

1 are excellent reasons to approve a new facility in
2 McHenry County. We are not going to deprive
3 existing facilities of their Medicare patients. We
4 will be providing a very nice facility for many
5 McHenry County Medicare patients who are not being
6 admitted into existing area facilities.

7 Madam Chair, in conclusion, because we have
8 an A-plus application, I respectfully request this
9 honorable Board to approve Project 15-044.

10 CHAIRWOMAN OLSON: Thank you.

11 Can I open it for questions? Or did you
12 have more comment?

13 MR. JENICH: I do.

14 CHAIRWOMAN OLSON: Okay. Please go ahead.

15 MR. JENICH: Thank you.

16 And thank you, Dan.

17 Board members, at the February Board meeting
18 Chairwoman Olson asked us to share distinguishing
19 features of this project. we took that question to
20 heart. After the meeting, in the time since, we
21 focused on this specific question and produced what
22 we believe is a thorough, comprehensive response
23 that has been included in our submissions and the
24 materials provided to you by staff.

1 For easy reference, I've provided you with
2 excerpts from that submission today. And, Mike and
3 Courtney, thank you for allowing those to be shared
4 with the Board.

5 To begin, please refer to the comparison
6 chart on page 3 of the handout as well as pages 4
7 through 13. Transformative Health of McHenry will
8 provide transitional care services in a caring and
9 supportive, homelike environment designed to bridge
10 the gap from hospital to home. This unique physical
11 plant and its care-delivery model is what
12 differentiates this project from all other existing
13 service providers in the area.

14 First, as written on pages 7 and 8, our
15 facility will have all private rooms. This means
16 98 private rooms with 98 private bathrooms and
17 98 private sinks, toilets, and shower facilities.
18 No other provider in the service area provides all
19 private rooms.

20 By comparison and by their own submission,
21 our opponents show that they have very few private
22 rooms. On May 31st Crystal Pines submitted a letter
23 of opposition showing that it only has 7 private
24 rooms in its 114-bed facility, and Crossroads, a

1 115-bed facility, reported only 4 private rooms.

2 Altogether, four opposing facilities
3 identified by Crystal Pines report 380 total beds,
4 but they only offer 35 private rooms. That equates
5 to less than 10 percent of their total beds. These
6 providers offer very few private rooms and even
7 fewer private bathrooms. Most of their private
8 rooms are actually conversions from double-occupancy
9 rooms where the majority of patients have to share
10 bathrooms, sinks, and toilet facilities. Patients
11 today strongly desire private rooms, and their
12 families strongly desire for their loved ones to be
13 in private rooms. Unfortunately, there are few
14 available in the service area today.

15 At a 98 count, our single facility will
16 offer nearly three times the number of private rooms
17 currently available at the four opposing facilities
18 combined. All our private rooms will include
19 attached private bathrooms fully equipped with
20 toilet, sink, and shower, designed to limit the
21 spread of infection and provide for a patient's
22 privacy, comfort, and, most importantly, their
23 safety.

24 Another significant physical plant

1 distinction is found on page 17 of your handout. On
2 page 17, here you will see that our total gross
3 square feet per bed per the project is one and a
4 half times larger than the required State minimum
5 and will be two times the size of the average gross
6 square feet per bed of existing providers in the
7 primary service area or the PSA.

8 Stated another way, our 700 gross-square-
9 foot bed facility as compared to the service area
10 average of 342 gross square feet per bed provides
11 for larger rooms and more common spaces that result
12 in added patient comfort and safety. Our single
13 private rooms will be larger than the average
14 double-occupancy rooms of existing providers.

15 Our facility will be new and modern. Also
16 on page 17 you will note that the average age of
17 existing facilities in the primary service area is
18 36 years old. The majority of the area facilities
19 were built in the early 1970s and before, and, for
20 the most part, these dated facilities are not being
21 modernized.

22 Next, please refer to page 18. On page 18,
23 here you will notice that Medicare and Medicaid cost
24 report information filed by the facilities

1 themselves. This table shows that, over the last
2 five years, the average annual capital expenditure
3 of existing facilities was only \$130,540 per year
4 per facility. Our project alone represents capital
5 expenditure over three times greater than what the
6 opposing area facilities report to the State Board
7 in the past five years combined.

8 Other important and noteworthy project
9 distinctions, Chairwoman, include an on-staff
10 psychiatrist, seven-day-a-week rehab staffing,
11 full-time physician services, realtime laboratory
12 and radiology services.

13 As noted in your handout, we have many other
14 distinctive features in our project that are
15 currently not available in the service area. All
16 these features are designed to promote healing,
17 improve patient care, improve patient comfort,
18 improve patient safety, and improve patient and
19 family privacy.

20 Patients will benefit from and thrive on the
21 comfort and convenience of this noninstitutional
22 alternative residence center, homelike environment.
23 As we have previously stated, most of the existing
24 area facilities were built in the 1970s or earlier,

1 and the vast majority of beds are in small,
2 multioccupancy rooms.

3 We're introducing an alternative way to care
4 for these patients because we know people are no
5 longer satisfied with this level of care, and this
6 may be a significant contributing factor as to why
7 PSA utilization levels are reported as being low.
8 In fact, McHenry County residents and their families
9 are leaving the county to seek care at facilities
10 like our proposed project.

11 Anecdotally, we are aware of at least three
12 facilities outside of McHenry County that are most
13 similar to the proposed project which have admitted
14 over 75 residents from McHenry County in just the
15 last year. These facilities are 45 minutes to over
16 an hour away. They don't show up on any State
17 inventory data because patients and families are
18 choosing to bypass existing providers because the
19 services that they desire do not currently exist in
20 the planning area.

21 As vocal as our opponents have been before
22 this Board, not one of them requested a public
23 hearing on our project, as they were all entitled to
24 do. Instead, they chose to come before you and

1 express opposition and ignore your own rules for
2 public participation by continually repeating the
3 same issue. Perhaps they don't want to publicize a
4 brand-new facility with 98 rooms is proposed for
5 McHenry or have the public comment on their own
6 facilities rather than reporting only nominal
7 expenditures for capital improvements over the past
8 five years. These area facilities represent the
9 type of old-style nursing homes which the public and
10 the industry are moving away from. Today, modern
11 patients demand modern services.

12 There are public policy makers who also wish
13 to see movement for the health care delivery system
14 that includes facilities like the one ours is
15 purposefully designed for. In the 2008 final report
16 to the General Assembly, the Illinois Task Force on
17 Health Planning Reform addressed the state of
18 long-term care industry in Illinois and encouraged
19 this health Review Board to consider the following,
20 beginning quote: "Consider how skilled nursing fits
21 into the continuum of care with other care providers
22 and to encourage modernization, more private rooms,
23 the development of alternative services, and current
24 trends such as resident-focused care in the

1 provision of long-term care services," end quote.

2 Our resident care focused -- our resident-
3 focused care project addresses each one of the task
4 force's desired reforms and provides the updated
5 level of care addressed in the 2008 final report.
6 More importantly, our project is specifically
7 designed to provide a continuum of care on the
8 campus of an existing acute care provider. This
9 project will provide higher staff ratios,
10 alternative clinical services, and amenities
11 designed to monitor patient changes in medicine,
12 promote healing, and manage the residents' total
13 well-being and families' peace of mind.

14 In every industry and in life, competition
15 is what drives innovation. Healthy competition
16 translates into everyone working to be his or her
17 best. From a health care system perspective, this
18 positively impacts patients in terms of cost,
19 quality, and accessibility to the latest treatments
20 and care models available.

21 Our project introduces health care
22 innovation into the service area, and this results
23 in a more affordable, convenient, efficient, and
24 accessible health care system, all of which are good

1 for the patients and ultimately benefit the
2 community.

3 In their book entitled "The Innovator's
4 Prescription: A Disruptive Solution for Health
5 Care," Dr. Jason Hwang of the University of
6 Michigan, Professor Clayton Christensen of the
7 Harvard Business School, and the late Dr. Jerome
8 Grossman, Harvard School of Government, state, "It's
9 not that health care is doing a poor job. It's
10 improving but it just doesn't change the way we want
11 it to."

12 For change to happen, what disruptive
13 innovation theory tells us is that it's almost
14 always a new entrant to the industry that figures
15 out another way of doing things. We are the new
16 entrant, and we have figured out a better way of
17 doing things. We are proposing this project before
18 you today to provide the residents of McHenry with
19 access to the future of transitional care. If we
20 want a more affordable, convenient, and innovative
21 health care delivery system, we must create it.

22 If our opponents choose to continue to treat
23 their patients in the same manner that they've been
24 doing it since the 1970s, in buildings that were

1 built in the 1970s, then, by all means, let them do
2 it. We certainly won't stop them, nor should they
3 be permitted to stop the development of new,
4 innovative, and modern facilities in McHenry County.

5 The data provided to you in your Board
6 packets indicates that this project will not hurt
7 the existing providers. The data is based on the
8 CMS cost reports filed by the opposition themselves,
9 and it shows that they are receiving hundreds upon
10 hundreds of patient referrals beyond what they've
11 actually admitted into their facilities. That's
12 right now. Can the State and this Board's
13 projections show that the local referrals will
14 increase dramatically due to the aging population?

15 As noted on page 7 of the Board -- of the
16 staff report, the five-year growth rate for the
17 65-plus age cohort in McHenry County is 31 percent
18 and the five-year growth rate for the 75-plus age
19 group is 25 percent. This is what creates a bed
20 need of 127 beds in the planning area, and this is
21 what the Board's methodology shows to allow all area
22 facilities, including our opponents' and including
23 our project, to be at target occupancy by 2018.

24 I developed this project and filed this

1 application because I relied upon and believed in
2 your data and your projections which support that
3 there was a need for more skilled beds in McHenry
4 County. Your projections were a fundamental factor
5 in our business planning, and I am personally
6 invested in that plan and those projections. A
7 substantial portion of my life savings is now
8 committed to this project. This is a project in
9 which I strongly believe, and this is a project that
10 is strongly supported by the Board's own data.

11 In closing and with consideration of the
12 information made available to you in our
13 application, subsequent submissions, and the
14 testimony provided here today, I wish to create --
15 reiterate or repeat the following set of facts.

16 Fact No. 1: There is an established bed
17 need for 127 beds in the planning area.

18 Fact No. 2: There is no surplus of beds in
19 the planning area as determined by both the staff
20 and the bed-to-population ratio. In fact, McHenry
21 has the lowest or the second lowest bed-to-
22 population ratio among all 95 statewide planning
23 areas, and it has less than half the beds per
24 individual than the State average.

1 Fact No. 3: As stated, our project
2 differentiates itself from a physical plant
3 perspective in that all of our beds will be private
4 rooms with private bathrooms, and no other facility
5 in the planning areas has all private rooms.

6 Fact No. 4: All of our beds will be dual
7 certified for Medicare and Medicaid, and our
8 financial projections track with what -- the
9 information that we see coming out of the hospitals
10 and will be a minimum of Medicaid patient volume of
11 10 percent.

12 Fact No. 5 --

13 MEMBER GALASSIE: There's not 75 of these
14 facts, are there?

15 MR. JENICH: There are 10.

16 MS. AVERY: 10.

17 MR. JENICH: And I'm almost done.

18 MEMBER GALASSIE: Thank you.

19 MR. JENICH: -- area providers relegated
20 over 250 beds and bed status. On page 7 of the
21 staff report, it shows that, in 2014, 254 of 997
22 beds were set up. That's almost one-quarter of all
23 planning area beds, and it is six times the State
24 average of dead beds. Again, that's six times the

1 State average for dead beds.

2 Reason No. 6 -- and I'm almost done, sir.

3 Thank you for allowing me to continue -- the Board's
4 bed-need projections show that the 65-and-older age
5 cohort in McHenry County are increasingly so rapidly
6 that all area providers will reach target occupancy
7 by 2018.

8 No. 7: Even now, CMS cost report data shows
9 that area facilities are admitting only about half
10 the patients referred to them from area hospitals.
11 Many McHenry County patients are leaving the
12 planning area seeking alternative skilled nursing
13 services elsewhere.

14 No. 8: Local patient referrals are not
15 currently being admitted to area facilities, and
16 these referrals will dramatically increase as the
17 population ages. Existing facilities will not be
18 adversely affected by the proposed project. There
19 are plenty of documented referrals in the planning
20 area to support both the area providers and this
21 project.

22 No. 9: The staff found that we met 18 of
23 20 criteria, and we have respectfully presented
24 extensive and compelling evidence to demonstrate our

1 substantial compliance with all 20 criteria.

2 No. 10: This project will deliver up-to-
3 date modern care -- modern nursing services in a
4 manner not currently provided in the planning area.
5 It meets all the concerns recognized by the Illinois
6 Task Force on Health Planning Reform in its final
7 report to the General Assembly, which encourages
8 this planning Board to consider modernization, more
9 private rooms, the development of alternative
10 services, and resident-focused care trends like this
11 project will provide. This project will most
12 assuredly have a positive impact on the residents
13 who desire access to alternative, high-quality,
14 resident-focused care and services in McHenry
15 County.

16 For all of the above reasons, we respectfully
17 request the Review Board approve Project No. 15-044,
18 Transformative Health of McHenry. This is a good
19 project for this community.

20 Thank you.

21 CHAIRWOMAN OLSON: Thank you.

22 Questions from Board members?

23 (No response.)

24 CHAIRWOMAN OLSON: That was pretty

1 comprehensive. Seeing no questions, I'll ask for a
2 roll call vote.

3 MR. ROATE: Motion made by Mr. Johnson;
4 seconded by Mr. Sewell.

5 Mr. Galassie.

6 MEMBER GALASSIE: Aye.

7 MR. MORADO: I'll ask you just to please
8 explain your vote.

9 MEMBER GALASSIE: I'm sorry.

10 MR. MORADO: Can you just explain your vote?

11 MEMBER GALASSIE: Oh.

12 Based on the discussion and findings of
13 staff, I'm voting aye.

14 MR. ROATE: Thank you.

15 Justice Greiman.

16 MEMBER GREIMAN: Well, I voted aye last
17 time, and, despite hearing all this, I'll still vote
18 aye.

19 MR. ROATE: Thank you.

20 Mr. Johnson.

21 MEMBER JOHNSON: Yes, based on the details,
22 defense of staff's findings, and explanation by the
23 Applicant.

24 MR. ROATE: Thank you.

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Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on the
testimony heard.

MR. ROATE: Thank you.

Mr. Sewell.

MEMBER SEWELL: Yes, based on the testimony,
the interpretation of the rules.

MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: Yes, based on testimony.
I think they addressed the negative findings
extremely adequately.

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

CHAIRWOMAN OLSON: The motion passes.
Congratulations, gentlemen.

MR. JENICH: Thank you very much.

(Applause.)

CHAIRWOMAN OLSON: Good luck.

- - -

1 CHAIRWOMAN OLSON: There's no other
2 business; there's nothing under rules development,
3 nothing under old business.

4 You have your financial report. If you have
5 questions, please address them to Courtney or Juan
6 or Jeannie.

7 I would like to have a motion to maintain
8 the July 2014 through December 2014 exec session
9 minutes confidential and closed.

10 May I have such a motion.

11 MEMBER JOHNSON: So moved.

12 CHAIRWOMAN OLSON: Can I have a second, please.

13 MEMBER GALASSIE: Second.

14 CHAIRWOMAN OLSON: All those in favor say aye.

15 (Ayes heard.)

16 CHAIRWOMAN OLSON: Opposed, like sign.

17 (No response.)

18 CHAIRWOMAN OLSON: Motion passes.

19 No discussion under bed changes, capital
20 expenditures.

21 You have a list of meeting -- oh, you
22 were -- I'm sorry.

23 You received a report on bed change, capital
24 expenditures for 2013 and capital expenditures for

1 2014 as well as the meeting dates for 2017. If you
2 have any questions, please let Courtney or Juan
3 know.

4 We are not firmed up on any of the sites for
5 2017, probably mostly because we haven't paid
6 anybody since 2014, so I think eventually we're
7 going to wear out our welcome. I think people will
8 be meeting at my house in 2017.

9 MEMBER GALASSIE: We'll second that.

10 CHAIRWOMAN OLSON: And, Mike, we have
11 corrections to one of the profiles?

12 MR. CONSTANTINO: Yes. We just need a voice
13 vote on this, Kath.

14 CHAIRWOMAN OLSON: Okay. Go ahead.

15 MR. CONSTANTINO: Rush -- go ahead.

16 CHAIRWOMAN OLSON: Go ahead.

17 MR. CONSTANTINO: Rush University Medical
18 Center, Advocate South Suburban, and John Stroger
19 are asking the Board's permission to change profile
20 information.

21 MS. AVERY: Nelson's reviewed this?

22 CHAIRWOMAN OLSON: Nelson has reviewed it
23 and concurs with the changes?

24 MR. CONSTANTINO: Yes.

1 CHAIRWOMAN OLSON: I think you have, as
2 well, Mike.

3 May I have a motion to approve corrected
4 data profiles for Rush University Medical Center,
5 2012, 2013, 2014 --

6 MEMBER GALASSIE: So moved.

7 MEMBER JOHNSON: Second.

8 CHAIRWOMAN OLSON: I'm going to do them all.

9 -- Advocate South Suburban Hospital for
10 2008, 2009, 2010, 2011, 2012, 2013, and 2014; and
11 John H. Stroger, Jr., Hospital for 2013 and 2014.

12 May I have a motion.

13 Dale -- Dale moved. Do I have a second?

14 MEMBER JOHNSON: Second.

15 CHAIRWOMAN OLSON: All those in favor?

16 (Ayes heard.)

17 CHAIRWOMAN OLSON: Opposed, like sign.

18 (No response.)

19 CHAIRWOMAN OLSON: Motion passes.

20 MEMBER SEWELL: Let the record show that
21 I abstained on that vote because the School of
22 Public Health has an active contract with the
23 Cook County Health and Facilities System, and I'm a
24 principal investor in that.

1 CHAIRWOMAN OLSON: Thank you, Mr. Sewell.

2 MEMBER MC GLASSON: Would my abstention be a
3 problem?

4 CHAIRWOMAN OLSON: It would.

5 MEMBER MC GLASSON: Then I vote aye.

6 CHAIRWOMAN OLSON: Okay.

7 Is there -- why did you think -- finally,
8 Juan, the interagency agreement.

9 MR. MORADO: Yes. I just passed out a copy
10 to you and to Mike and George -- and, Melanie,
11 I apologize; I don't have your copies yet.

12 But there's only two changes from the IGA
13 that was approved last year. One change is that the
14 Board will now provide IDPH with a copy of our
15 personnel handbook, and the other change is that we
16 are going to be asking for the consultation with
17 HFSRB-IDPH regarding the number of staff designated
18 to us to happen by a certain date. In this case,
19 that would be by June 15th of the next fiscal year.

20 So we already have in our IGA that IDPH will
21 consult with us regarding who gets assigned to work
22 on Board matters. Those meetings, as I understand
23 it, have not happened. So it's been in writing but
24 it hasn't quite happened yet, so we're hoping to

1 strengthen that part a little bit more.

2 CHAIRWOMAN OLSON: And you would like a
3 motion to approve?

4 MR. MORADO: Yes.

5 CHAIRWOMAN OLSON: May I have a motion to
6 approve the HFSRB-IDPH interagency agreement.

7 MEMBER GALASSIE: So moved.

8 CHAIRWOMAN OLSON: And a second.

9 MEMBER SEWELL: Second.

10 CHAIRWOMAN OLSON: Thank you.

11 Any other questions or comments?

12 (No response.)

13 CHAIRWOMAN OLSON: Seeing none, I would call
14 for a voice vote. All those in favor say aye.

15 (Ayes heard.)

16 CHAIRWOMAN OLSON: Opposed, like sign.

17 (No response.)

18 CHAIRWOMAN OLSON: Motion passes.

19 I would like to just make one very quick
20 announcement.

21 I'd like to recognize Barb Haller. Is she
22 still here?

23 We want to thank you for all of your
24 services at the Illinois Health and Hospital

1 Association. And enjoy your retirement.

2 MS. HALLER: Thank you.

3 CHAIRWOMAN OLSON: And I'm very jealous.

4 (Applause.)

5 CHAIRWOMAN OLSON: Okay. Our next meeting,
6 August 2nd in Chicago, Michael A. Bilandic Building.

7 It will start again at ten o'clock a.m.

8 And I will proceed --

9 MS. AVERY: Across the street from me.

10 MS. MITCHELL: It's across the street from
11 the Thompson Center.

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

13 CHAIRWOMAN OLSON: The next meeting, on
14 August 2nd, is at the Michael A. Bilandic Building
15 in Chicago.

16 May I have a motion to adjourn.

17 MEMBER JOHNSON: So moved.

18 CHAIRWOMAN OLSON: And a second.

19 MEMBER SEWELL: Second.

20 CHAIRWOMAN OLSON: All those in favor?

21 (Ayes heard.)

22 CHAIRWOMAN OLSON: Thank you, everybody.

23 (Off the record at 4:33 p.m.)

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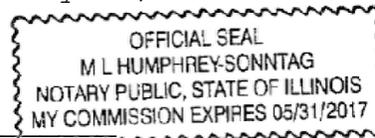
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CERTIFICATE OF SHORTHAND REPORTER

I, Melanie L. Humphrey-Sonntag, Certified Shorthand Reporter No. 084-004299, CSR, RDR, CRR, CRC, FAPR, 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 11th day of July, 2016.

My commission expires: May 31, 2017



Notary Public in and for the
State of Illinois

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