Transcript of Full Meeting

Date: June 20, 2017
Case: State of Illinois Health Facilities and Services Review Board
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
HEALTH FACILITIES AND SERVICES REVIEW BOARD

OPEN SESSION - MEETING

Bolingbrook, Illinois 60490
Tuesday, June 20, 2017
10:00 a.m.

BOARD MEMBERS PRESENT:
KATHY OLSON, Chairwoman
RICHARD SEWELL, Vice Chairman
BRAD BURZYNSKI
SENATOR DEANNA DEMUZIO
JOEL K. JOHNSON
JOHN MC GLASSON, SR.
MARIANNE ETERNO MURPHY

Job No. 126145
Pages: 1 - 303
Reported by: Melanie L. Humphrey-Sonntag,
CSR, RDR, CRR, FAPR
EX OFFICIO MEMBERS PRESENT:

    BILL DART, IDPH
    ARVIND K. GOYAL, IHFS

ALSO PRESENT:

    JUAN MORADO, JR., General Counsel
    COURTNEY AVERY, Administrator
    MICHAEL CONSTANTINO, IDPH Staff
    GEORGE ROATE, IDPH Staff
    JESSE NUSS, Board Intern
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(Member Goyal was not present.)

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

May I have a roll call, please.

MR. ROATE: Thank you, Madam Chair.

Mr. Sewell.

VICE CHAIRMAN SEWELL: Here.

MR. ROATE: Ms. Murphy.

MEMBER MURPHY: Here.

MR. ROATE: Mr. McGlasson.

CHAIRWOMAN OLSON: He's here -- oh, here he is.

MR. ROATE: Mr. Johnson.

MEMBER JOHNSON: Here.

MR. ROATE: Mr. Ingram's absent.

Senator Demuzio.

MEMBER DEMUZIO: Here.

MR. ROATE: Senator Burzynski.

MEMBER BURZYNSKI: Here.

MR. ROATE: Madam Chair.

CHAIRWOMAN OLSON: Here.

MR. ROATE: That's eight in attendance.

CHAIRWOMAN OLSON: Thank you.
The first order of business is executive session.

May I have a motion to go into closed session pursuant to Sections 2(c)(1), 2(c)(5), 2(c)(11), and 2(c)(21) of the Open Meetings Act.

May I have a motion.

MEMBER JOHNSON: So moved.

CHAIRWOMAN OLSON: And a second.

MEMBER BURZYNSKI: Second.

CHAIRWOMAN OLSON: All those in favor?

(Ayes heard.)

CHAIRWOMAN OLSON: We're now in executive session for approximately 20 minutes.

Oh, I'm sorry. Let the record reflect there are seven in attendance.

So I'll need everybody to clear the room.

We are going to be in executive session for about 20 minutes.

(At 10:01 a.m. the Board adjourned into executive session. Member Goyal joined the proceedings, and open session proceedings resumed at 10:34 a.m. as follows:)

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

Juan, are there motions to come out of exec
session?

MR. MORADO: Yes.

Madam Chair, we're going to be seeking a
referral of the Clark-Lindsey Village matter to
legal counsel.

CHAIRWOMAN OLSON: May I have a motion to
refer Clark-Lindsey Village to legal counsel.

VICE CHAIRMAN SEWELL: So moved.

MEMBER BURZYNSKI: Second.

CHAIRWOMAN OLSON: All those in favor
say aye.

(Ayes heard.)

CHAIRWOMAN OLSON: The motion passes.

Anything else?

MR. MORADO: Yes. We have a -- we're
seeking a motion today for a final order on the
Clark-Lindsey Village matter.

CHAIRWOMAN OLSON: Do this one more time.

May I have a motion to approve a final order
on the Clark-Lindsay Village matter.

MEMBER DEMUZIO: Motion.

CHAIRWOMAN OLSON: Second?
MEMBER JOHNSON: Second.

CHAIRWOMAN OLSON: All those in favor say aye.

(Ayes heard.)

CHAIRWOMAN OLSON: The motion passes. The final order is approved.

MR. MORADO: And, finally, we're seeking a final order on the Neighbors Rehabilitation Center, Project 14-008, also known as HFSRB 16-12.

CHAIRWOMAN OLSON: May I have a motion to approve this project.

MR. MORADO: Final order.

CHAIRWOMAN OLSON: Final order. I'm sorry.

MEMBER DEMUZIO: Motion.

CHAIRWOMAN OLSON: Second?

VICE CHAIRMAN SEWELL: Second.

CHAIRWOMAN OLSON: All those in favor say aye.

(Ayes heard.)

CHAIRWOMAN OLSON: The motion passes. The final order is approved.

MR. MORADO: Thank you.

CHAIRWOMAN OLSON: Thank you, Juan.

The next order of business is approval of
the agenda.

May I have a motion to approve the agenda.

MEMBER DEMUZIO: Motion.
MEMBER BURZYNSKI: Second.
CHAIRWOMAN OLSON: Motion. Second?
MEMBER MC GLASSON: Second.
CHAIRWOMAN OLSON: All those in favor say aye.

(Ayes heard.)

CHAIRWOMAN OLSON: The agenda's approved.

May I have a motion to approve the meeting transcripts of the May 2nd, 2017, meeting?

MEMBER DEMUZIO: Motion.
CHAIRWOMAN OLSON: And a second, please.
MEMBER JOHNSON: Second.
CHAIRWOMAN OLSON: All those in favor say aye.

(Ayes heard.)

CHAIRWOMAN OLSON: Motion passes.

The next order of business is Long-Term Care Facility Advisory Subcommittee educational session.

Juan, do you want to introduce this, please?

MR. MORADO: Yes.

So recently I've begun working with the
Long-Term Care Advisory Subcommittee.

And some of you may recall -- I believe it was two meetings ago -- we came before this Board to give our annual report and recommendations on a possible buy/sell program.

Since that time we've had some opportunities to reconvene and thought that it would be best if, moving forward, what we did for the Board was provide them with some additional education on a number of issues that are affecting the long-term care industry, and, you know, some of these issues are going to be very specific to long-term care, some that will be more general towards the health care services in Illinois.

And what we have today is a presentation on the Medicaid -- not just the Medicaid application process but Medicaid reimbursement -- and how that's been affecting the long-term care industry.

So we have a number of members from the Long-Term Care Advisory Subcommittee with us today. I'll give them an opportunity to introduce themselves.

CHAIRWOMAN OLSON: Please speak directly into your microphones for the court reporter. There
are two mics.

MR. MORADO: And before you begin,
Mr. Chairman, I'm going to go ahead and pass around
some documents which we're going to be referring to
during our presentation.

CHAIRMAN WAXMAN: Good morning. My name is
Mike Waxman, and I am the chairman of the
subcommittee.

MR. LAVENDA: My name is Steve Lavenda.

MR. FOLEY: Yes. My name is Charles Foley,
F-o-l-e-y.

MR. GAFFNER: I'm Alan Gaffner, a member of
the Alden network of long-term care as my employer.
I represent the member facilities of the Health Care
Council of Illinois on the Long-Term Care
Subcommittee.

CHAIRMAN WAXMAN: First of all, we'd like to
thank the members to allow us to come in and spend
some time with you and provide some education.

I think this committee's been functioning
for a number of years, dealing with some very
serious issues in terms of long-term care, and the
opportunity to share with the Board is welcome, and
the opportunity to provide some information that you
may not be aware of is also appreciated, and that's kind of what we're going to be doing over the next few months.

But today, just to kind of highlight where we are, the marketplace in Illinois, like most states, is undergoing a lot of change and a lot of differentiation among types of options for our senior citizens.

And I think we have to remember that, even though we may be representing facilities or representing organizations, that our purpose is to make sure that our seniors and others that need long-term care are able to get the types of care at appropriate levels with a payer source that is able to make it all happen. And so that's part of what our issues are.

If you look at the marketplace and talk about long-term care, there are very -- there are segments to the long-term care market. It's simply not one size fits all.

And, you know, there is the original long-term care skilled building; the ICF building, which is intermediate care, licensed by Public Health; and sheltered care. And there is a
tremendous growth that is outside that jurisdiction of buildings that are referred to as assisted living, independent living, memory care, and, you know, now you have the dichotomy of who is governing which segment of that world.

What's unique about it is that the assisted living, independent sheltered care, or independent memory care is basically a private-pay environment. You know, there aren't any third-party pay programs that will cover someone moving in. The reason they're growing in popularity is because they're brand-new, they look beautiful, and people who are making decisions about where their loved ones should go -- or the loved ones themselves -- are looking at brick and mortar and the gyms and the cafeterias and sometimes forgetting about the level of care that is needed to protect that resident.

And so you have situations that are kind of iffy, in some of our opinions, where people are in the wrong place at the wrong time, so something is going to have to be done about that.

The other thing is that, when I drive from my residence in the northern part of the state to -- from Lake County into DuPage County, I see seven
brand-new buildings that are either recently opened or to be opened rather shortly, which is all well and good except that you've got two issues that have to be dealt with: A, how are you going to staff them, knowing that long-term care, the traditional long-term care, is always fighting for staff? You know, when somebody says, "I can make X dollars at a quick food place or X dollars at a long-term care. Where am I going to go?" And long-term care has a great deal of extra work with elderly, and the work is much different than standing in front of a cash register and saying, "Would you like coffee with your hot dog?" versus "I have to change a diaper." So it's hard sometimes to get staff. Currently in the industry -- and now you have the influx of all these brand-new buildings.

So let's say they can staff them. Now, where are the residents coming from, given that it's a private-pay environment, given that nursing homes across the state are averaging about 78 percent occupancy? So where are they going to pull residents from? So it's an issue that needs to be looked at.
And to be quite honest, our committee has sent several hours, several meetings, several months looking at that. As some of you know, part of getting a CON approved to build a new nursing home or remodel one is that we have to deal with the question of whether or not Illinois is overbedded. And based upon the bed need formula, the answer sometimes is yes.

What I'd like to put on the table, just for you to be aware of, is that the bed need formula consists of two pieces: One is the formula itself, the actual mathematical calculations, and the second is the numbers that go into that.

Now, we spoke last time about this problem, and I'll do it briefly again. What nursing homes tend to report are licensed beds, and that's what goes into the formula; however, most nursing homes today are not operating at the licensed bed level.

So, for an example, I may own a home that has a license for 150 beds, but, for a variety of reasons, I may have converted some of those rooms into offices, into gyms, into activity rooms, or I simply have taken the beds out because I don't have the demand for them, so I'm operating with
125 beds.

So now our formula is counting 150 beds when, in fact, there's only 125 beds available. So is that bed formula really that useful?

The other question becomes the bed formula does not really take into account what I think is most important, which is the demand, what our consumers want from our long-term care facilities.

If they're looking for a cardiac rehab unit or a dialysis unit, for example, in a long-term care building and they're sitting in an area where there are four or five nursing homes, none of which have those kinds of options available, then are we really overbedded?

So I think we have to continue to look at what the needs are and the variations of ways of providing services, another issue that needs to be addressed somewhere.

The application talks about a 90 percent occupancy. The question becomes, in this world today where we're living in, 76, 78 percent occupancy, is the 90 percent rule really valid anymore?

So, again, something that needs to be
discussed, something that our committee is working on. We have taken research -- on all these questions, by the way, we have had other states' information brought to us so that we can compare what's going on in our surrounding states with what's going on in Illinois. So, you know, we're not trying to make decisions in a vacuum.

We have membership, I think, that's extremely diverse, and I think it's an incredible group of individuals, especially from where we started to where we are today. It's become a much more cohesive group, a much more active group, and a group that really wants to represent the long-term care industry however it's defined.

So, again, it represents for-profit, not-for-profit, religious-based organizations. It represents providers, advocates, and some other types of people who are involved in selecting long-term care sites, long-term care buildings for others. So that, I think, is important.

I talked about staffing issues.

Buy/sell -- we've spent several long meetings talking about buy/sell, and, again, to remind you, what we're talking about is a couple of
variations in the buy/sell transfer agreement.

For example, in its simplest form, if I may use the gentleman to the right of me, his organization, Alden. Alden, they have a building in the southern part of the state that has 50 beds they aren't using. They may have a building in the northern part of the state where they have a demand for 50 beds. So can they be allowed to simply transfer the beds and the license from Point A to Point B?

Second, there may be a sole proprietor in the southern part of the state that has 25 beds that they're not using. Can that sole proprietor transfer the beds to another sole proprietor in the northern part of the state, beds and license?

Or we may have a group of homes downsizing and somebody in another area that wants to either start a building or increase their beds. And can those beds be bought and sold?

It raises a tremendous amount of questions about, you know, what is a bed worth. And remember that, for most nursing home ownerships, that bed and the license attached to it is part of their financing arrangement, so their lender has based
their lending limit on the value of that licensed bed. If that bed doesn't exist, now what happens to the loan at the building that moved it away? And what can we do, as a committee, to make sure that any money that is gained from the movement of beds is put to good use?

Good use. Into the homeowner's pocket?

That's not a good use. Used to improve the conditions of the buildings that they're moving the beds to? Good use.

How do we make that happen? What mechanisms do we have that can ensure that, if there's movement of money from Home A to Home B, that Home A uses the money that they've received to improve the conditions, improve the clinical care, improve the operations of the building?

Versus how do we ensure that the people who are receiving the beds are worthy of being an operator that we would want to refer somebody we know to that building? Questions that we have many discussions about and, again, not agreed-to answers.

I've talked about the effect on the assisted-living facilities. I want to make it clear because I've been accused of being an enemy of
assisted living. I am not. I'm simply saying that there are some assisted-living buildings that I think are amazing and are well put together and provide the services that they're supposed to.

I'm only questioning whether we have the right tools in place to ensure that, when families make decisions about where Mom should be, are they doing it with the best information possible. The intentions are all well. No question about that.

When you look at the brick and mortar and the cafeterias and what looks like exercise rooms, I mean, it's hard to say that's the wrong place compared to a skilled building that's 30 years old if that skilled building has 24-hour nursing care, in some cases where those nurses have the ability to take care of higher acuity.

Remember that hospitals are discharging faster. I'm sure that's not new information to you. They're discharging faster and discharging sicker. So where should those people end up to maintain their health, their quality of life, and their ability to continue to survive? Because I think everyone believes that the goal of anyone going into a long-term care facility is to go back home. So
how do we make that happen?

    So those are the kinds of things that we are
looking at and dealing with. There's some other
things that we'll bring to you, but those are the
kind of things that, as you afford us the
opportunity to share information with you, we will
develop those subjects into broader and more
detailed information.

    As Juan said, today we want to talk about
Medicaid. Medicaid is the State-funded program --
well, it's Federal funded and the State enacted --
that reimburses nursing home residents. The two
third-party payers that are important to a nursing
home are Medicare and Medicaid.

    Medicaid is a program to help those that
can't financially afford to pay out of pocket or,
for whatever reasons, do not qualify for Medicare A
benefits. Medicare A benefits pays for room and
board, Medicare B pays for ancillary services, and
Medicare D is the pharmacy piece of it -- and,
again, I'm probably repeating things that you
already know, but it just feels like I should.

    So Medicaid then picks up the room and board
charges for nursing home residents in the state of
Illinois, and we'd like to share some information about the program, how it's evolved over the years, and where we view it currently. And we'll start with Steve.

MR. LAVENDA: Thank you. Again, my name is Steve Lavenda. I am a partner at the accounting firm of Marcum, LLP.

I've been involved in the nursing home reimbursement area for a little over 35 years, 33 of those years here in Illinois, so I'm very familiar with how the Medicaid system reimburses nursing homes here in Illinois.

But -- is it coming through?

So what Juan passed out to you was a chart I put together kind of giving a history of Medicaid reimbursement starting with July 1, 1993, because that was -- what I'll call -- the last normal year when it came to cost reimbursement.

Shortly after that fiscal year began, in January of 1994, the State put a freeze on the Medicaid reimbursement, and, from that point forward, there have been two rebasings of the support and capital rates -- and I'll go into the makeup of the Medicaid rate in just a little bit.
But just -- a rebasing was done just twice in almost 25 years, once using the 1999 or 2000 cost reports for July 1, 2001, and then again on January 1st of 2008, using either the 2003 or 2004 cost reports.

So -- and since then and even prior to that, all there was was either inflationary increases or, as this charts points out, there were actually decreases in addition.

So, yes, there have been some rebasings, but considering that the last one was based on the 2004 cost report, which is 13 years ago, that's -- there's a lot of years in the middle in which operating costs, which some -- most of which can't be controlled -- have increased, and the amount that the homes get reimbursed is a lot less than what they're actually paying out.

As I mentioned, the Medicaid rate's made up of, basically, three different components. And, again, I've broken them down for you on page 2, nursing, support, and capital. The nursing component is based not on cost but based on an assessment tool called minimum data set, also known as MDS, and those rates do change every quarter, based on the assessments which are filed for the
quarter before.

And although, when that system was put in place, the homes did see some increase in the nursing component of the rate, it's also more of a yo-yo. I mean, one quarter could go up, next quarter could go down. It all depends on patient mix. It depends on the -- the staffing, how people fill out the MDSs. So there's not a lot of consistency.

In addition to nursing, the support component, which is the only truly cost-reimbursed portion of the rate, which is for your overhead, such as dietary, housekeeping, laundry, linen, maintenance, some administrative costs -- again, those are things that you have to pay that may not relate to direct care but certainly things that you need to run the nursing home. And that, again, hasn't been updated since the 2004 and 2003 cost report.

Finally, you have the capital component, which goes based on a very complicated, convoluted formula, which, depending on when your building was either bought or leased, can help determine the rate. And there have been some increases in the
base part of the capital rate, depending on if a nursing home owner or nursing home group decides to put a certain amount of capital improvements in the building, and then they can qualify every June 30th for a capital rate increase I know our office ends up filing about 30 to 40 of these every year for various amounts of increases.

However, one thing that Mr. Waxman touched on is the building of new buildings, modernized buildings. The cost to build a new building is somewhere approaching $200,000 a bed, depending on the area of the state you're in. The actual amount in the capital formula -- which hasn't been updated since 2001 -- the actual cost per bed that they allow is closer to $50,000. So, again, there's not a lot of incentive to build new facilities in the state and to modernize to better serve the residents.

Finally, in the capital portion or the rate there's also a component for real estate taxes, and the real estate taxes you get reimbursed based on your actual bill except that component has been frozen since July 1, 2001, which -- what was used to calculate that was the 1998 bill, paid for in 1999,
so that is a lot of intervening years in which the
taxes have gone up for which -- and the homes are
not receiving any reimbursement for.

I know a lot of providers we work with do
protest the bills, and they are able to somewhat
keep them in line, but then there are others that
have gone up 2-, 300, 400 percent over this time
period.

And what that does, you know, in all these
different things with the freezes and the percentage
decreases and the lack of incentive to invest in
your building, you know, it just further widens the
gap between the actual gap a nursing home receives
in reimbursement from Medicaid and what they're
actually spending.

And the last time I looked at the 2015 cost
report database and did a comparison, where the
actual costs for a nursing home -- the difference
between what the costs were and what the
reimbursement rate was was almost $66 a day, on
average. So some of that may be made up with
Medicaid revenue, some with private pay. But for
the homes where it's a fixed or a large Medicaid
population, that puts a very big hardship on the
operator.

So I will turn it over to Alan.

MR. GAFFNER: Thank you, Madam Chair and members of the Planning Board, for your invitation to start this education process today following our time with you in January. As a representative of a provider, I'm encouraged and appreciate your interest in the future of long-term care within the state.

The Alden network of long-term care has approximately 40 facilities that span from the north shore area of Chicago to Rockford on the west and span the continuum of care from independent to assisted living, supportive living, freestanding memory care, rehabilitation care, and then skilled long-term care.

My assignment today is to frame and put in perspective the impact of the Medicaid reimbursement rate within the state. Steve has identified the facts associated with that rate history; mine is to try to bring it into 2016 terms and its impact upon operation that ultimately directly impacts quality of care to residents.

The Illinois Medicaid long-term care
reimbursement rate is the 49th lowest in the nation. I have, again, verified this information since being with you in January by using the American Health Care Association and the research that they do as the country's premier association that represents long-term care providers at the Federal level. Steve shared with you the rate is approximately $66 per day below the costs of providing daily care. For one Medicaid resident in a long-term care facility, the shortfall is $24,090 annually. The average Medicaid utilization in an Illinois long-term care facility is 75 percent. If we use a 100-bed facility, that would allow our math to be very simple. With the Medicaid utilization of 75 percent, the yearly loss is $1.8 million for the cost of providing care to the Medicaid residents in that building. It is impossible to recover this loss through charges to private-pay residents. And there was a saying for many years that, "Well, you could make it up on the private-pay community." It's no longer possible, if it ever was. First, I would disagree with that. Two factors today make that totally impossible. First,
even private-pay residents entering a facility enter
the Medicaid program more quickly than ever before.
They've simply outlived their resources.

Secondly, with the increasing costs that are
associated with providing care, it's impossible to
pull that into the private-pay rate.

Medicaid-pending applications have become a
very significant problem within the state. They've
added to the already fragile financial viability of
long-term care providers.

A Medicaid-pending application is the
process of taking someone who is applying for
Medicaid coverage -- they may enter the nursing home
with no Medicaid coverage or, while receiving care
in the facility, they've exhausted their personal
funds and now must apply for Medicaid long-term care
benefits. The application process is intended to
appropriately determine if personal assets are
depleted with no inappropriate transfers of assets
to family members or others.

The number of Medicaid-pending applications
for individuals seeking coverage has reached an
epidemic proportion. There has been a marked
slowdown in the ability, on behalf of the State, to
process those applications and make a determination of either Medicaid eligibility or no Medicaid eligibility.

The number of applications awaiting determination has increased significantly over the past five years, and it's very common for a period of 18 months or more to expire before Medicaid eligibility is determined.

Often a resident may pass away before a determination is made. State statute requires that, in essence, that application start over again with the assistance of an advocate or a representative, and so you basically move to the back of the line.

During the time that the long-term care resident is awaiting determination, the facility does not receive Medicaid or private-pay reimbursement for the care provided. The cost of care exists each day while no payment is received. If Medicaid eligibility is approved, payment will be made retroactively; however, if Medicaid eligibility is denied, no payment from the State will be made for the care rendered.

At the present time it is estimated that the total costs associated with Medicaid-pending
long-term care applications is between $200 million and $300 million statewide. It is unlikely the State has the financial capability of making these payments without borrowing the funds.

I'd like to share with you three very real-world financial ramifications that exist as a result of Illinois' Medicaid long-term care reimbursement rate, the combination of that 49th lowest reimbursement rate in the nation and slow Medicaid payments.

Illinois has historically been anywhere from sometimes 3 months, 9 months -- I remember a time in the facility where I was employed, 18 months -- behind in making payments. They've placed the Illinois long-term care providers in greater financial peril than ever before.

Here's the first example I would share: A chain of approximately 10 long-term care facilities located from Chicago to downstate is now in receivership. There has been little interest expressed by potential buyers of the properties. If the facilities close, residents will be forced to find another provider that may not be in proximity to their community or family members.
A second financial ramification: Vendors who supply long-term care facilities wait months for payment as a result of cash flow shortages.

Example No. 2: MEDLINE, one of the nation's largest suppliers to long-term care facilities, is currently on payment terms of 180 days or six months with a multifacility long-term care provider in Illinois. This payment delay has ramifications for the supplier as well as the provider, as both are incurring increased costs as a result of the interest to carry the debt.

A third ramification: Lending institutions are now requiring more financial data and security than ever before to provide operating capital or funding for renovations or new construction. This is applicable whether it's a single owner or whether it's a multifacility organization.

An example that I received two weeks ago while we were in Washington, DC, meeting with members of Congress regarding the ongoing Federal reform of health care, I was in the Congressman's office, and the single facility owner in the rural area of Northern Illinois shared that he recently was required by his banker to mortgage his personal
home as collateral for operation of his long-term care facility.

He's been an owner-operator for decades, not an owner new to the profession, has a longtime history behind him. But he shared with us, as we were just now amazed at this new requirement, that he has mortgaged his own home as collateral to keep his long-term care facility in operation.

The inability of long-term care providers to meet fixed costs, increasing costs of labor, and property taxes, as Steve identified, has created this financial, very perilous situation because the revenue flow for 75 percent of the business is no longer adequate.

And I share with you that across the Medicaid provider community that there is the desire to offer a higher wage level. In fact, in my conversation with providers from the southern part of the state to the northern part of the state, they all are facing staffing challenges because they are losing or unable to hire staff that now identify, when they are interviewed or upon leaving, that they are receiving higher wages at retailers such as Walmart or Target or at convenience stores than they
are receiving within the long-term care setting, not because there is an effort to say "We're not going to pay you more" but the inability, from a business modeling perspective, to pay more and make it sustainable.

And this was, again, a common theme that was shared two weeks ago from providers across the country, and the fear of what may be occurring with the Medicaid program as it makes its way through Congress has an exponential impact on Illinois because of the Illinois financial situation. I'll leave you with these outlooks that give both a State and a national perspective.

Here's a positive: Most acute settings are a lower cost provider than hospitals. They are 85 percent less expensive. The rehabilitation work that's offered in long-term care facilities, compared to what would be offered in an acute care setting, same type of rehabilitation, same type of care, is 85 percent less expensive. That's a positive.

The Federal government has proposed -- and in the Federal reform of health care that was passed by the House of Representatives, there are
unprecedented cuts to the Medicaid program.
Concerns about block grants, concerns about
per capita caps, these reductions have direct impact
on Illinois.

Currently the average operating margin for
long-term care providers nationwide is 0 to
2 percent. As I share that with others in the world
of commerce or business or manufacturing, they're
amazed. Their response is, "Why would you even want
to enter that business if you knew your likely
margin would be 0, breakeven, or something as small
as 2 percent?"

Regulations and requirements add annually to
the cost of providing care. Increased operating
costs further reduce the margins, pushing them into
a negative position.

At a time the baby boomers are aging rapidly
and life expectancy is increasing, many believe that
a shortage of long-term beds is approaching.

I was at the Del Webb community in Huntley
last week receiving a legislative update. That
community has 7,000 residents. An investment broker
in the community and another retailer were telling
me that they're seeing that community's residents
now leaving because they need care in other
settings. They've been in that independent
community long enough that now they're having to
seek other care levels.

I believe that's the start of that tidal
wave that we're going to see wash over us: Those
residing in those assisted-living facilities or
communities are no longer able to remain independent
or appropriately receive the intensity of home
health care required could be without long-term
care.

Decreasing Medicaid rehabilitation rates
from the Federal government that provided a limited
subsidy for low Illinois Medicaid long-term care
rates have been reduced. For organizations that own
their own pharmacy, therapies, and home health
divisions -- that many times were started as a
necessity to subsidize the long-term care rate --
have now seen these payments decrease.

We've really seen the lifeboat, which was
the Medicare program for Illinois long-term care --
it has now hit an iceberg and is sinking, as well.
No one is paying reasonably and appropriately for
the cost of providing care.
Knowledgeable professionals in Illinois believe that in 2017 there could be record numbers of long-term facility closures or sales as a result of the Medicaid funding crisis in Illinois. At a recent conference in Chicago, this observation was presented by several national experts.

Old Medicaid-heavy facilities are of little interest to most institutional capital sources. Non-CON states offer the challenge, as well. Repeal of the Federal Affordable Care Act adds to the uncertainty and risk. These factors, as their common denominator, have at their center an impact and outcome on availability and quality of long-term care in Illinois.

Thank you.

MR. MORADO: Thank you, Alan.

So another sheet you have in front of you is the Medicaid application process that kind of breaks down, over a page and a half, what actually happens when someone is seeking Medicare certification -- or Medicaid certification. Excuse me.

There's a number of different steps in there. We talked a little bit about some of the delays and the effects of those delays, so we wanted
to make sure you had this information.

   Generally speaking, you may be asking
yourself -- some of the things mentioned, some of
the issues mentioned this Board doesn't have direct
jurisdiction over, and that is absolutely true.

   But part of the reason we wanted to make
this presentation to you today is, as you well know,
we have applications that come before this Board for
either new long-term care facilities or
modernizations of facilities, and a lot of different
statements are made by these folks. And I get the
sense that the Board itself may not have all the
information that they would like to have before
they -- before they're hearing the presentation.

   So this education session, in particular,
was to give you some more background on Medicaid, to
allow some of the members of this committee to tell
you about the issues that are facing them so that,
when either they or other folks from the long-term
industry come before this Board with an application,
you'll have a better sense of what the landscape is,
and perhaps it's more information for you to ask
better questions and to engage with the Applicants.

   But I really want to thank the members for
taking their time to put this together. I wanted to give the Board an opportunity to ask some questions. And if you have anything at all, we have the Board members here.

CHAIRMAN WAXMAN: Juan, if I may, I'd kind of like to follow up on your last comment.

We certainly know that you do not have the ability to fix all the problems that we have presented. But we did want to share with you what we're seeing, being closer to the issues on a day-to-day basis and hope that we can work together with your power and your knowledge and your connections to figure out how we can make some changes to the environment because the last thing we want to see happen is what Alan spoke about, facilities closing.

I mean, there is nothing -- you know, there -- I've heard story after story of opportunities for people to want to move or be moved out of a nursing home and go into a community living center, and the people don't want to because this is their home that they've known for the last 10 or 15 years. This is where they're comfortable at.

So we don't want to get into that situation
where we have mass movement of people out of nursing homes into other areas, be it another nursing home someplace away, so it's important that we try to find some solutions to allow the owners and operators to at least maintain some profitability, something slightly above breakeven, so that they can continue to provide the services.

And I'd like to, again, just take a second -- you know, from an old accounting perspective -- that without a profit -- and, again, not-for-profit organizations must have a profit to continue business. If you don't want to call it profit, excess revenue over expenses. It works the same way.

But without that bottom line in a positive situation, you can't improve clinical services, you can't hire better staff, you can't hire the staff that you need, you can't make the improvement to the heating and air-conditioning system and the dietary programs. So these operators do need some relief in what they're looking at.

So, again, our purpose was to provide information, as Juan said, and to see if there are some ways that we can all work together so that we
can take our messages to appropriate people that can make changes, and we certainly are available to do that, and we look forward to future meetings with you to broaden the topics and get into some more detail.

And we are here to answer any questions that you may have.

CHAIRWOMAN OLSON: I think you've certainly given us a lot to think about and to continue on with the conversation.

Thank you so much for all your efforts and work that went into the presentation today.

I am going to move the meeting along because we have over 50 people for public participation, so we're going to have to move. But we certainly will look forward to further conversations and thank you for all your efforts.

We also are working on a Board liaison to make sure that we have somebody in attendance at your meetings so we'll be able to keep in better contact.

So thank you very much. We appreciate it.

CHAIRMAN WAXMAN: Thank you.

MR. GAFFNER: Thank you.
CHAIRWOMAN OLSON: The next item of business is public participation. Juan's going to read the names today.

We have over 50 people here for public participation, so when your two minutes are up, you're going to hear, in George's loudest voice, that your two minutes are up. I will ask that you finish your sentence and stop. We have too many people to allow people to go on.

Also, we're going to call everybody's name once -- or twice. If you miss your name, if you miss your call, we're going to have to move on.

So two minutes. And when you're done at the table, please make your exit rapidly so we can get the next group up.

The court reporter would appreciate you speaking into the microphone loudly, and please spell your name. And if you have written comments, if you'll leave them with Michael Constantino, we'll make sure the court reporter gets those, as well.

Do you have anything to add, Juan?

MR. MORADO: No. That's all.

Yes, please just make sure, if you have any comments, that you give them over and spell your
name clearly for the court reporter, both first and last name.

The first project we're going to be having comments on is Dialysis Care Center of McHenry. That's Project No. 16-058.

And I have the following four names:

Dr. Mohammad Zahid, James Dilts, Dr. Karol Rosner, and Dr. Michael Braun.

If you could step on up to the front so you can give your comments, you don't have to go in that order. But please sign in, spell your name for the court reporter.

CHAIRWOMAN OLSON: Okay. We're going to call those names one more time, and then we're going to move on.

MR. MORADO: Dr. Mohammad Zahid, James Dilts, Dr. Karol Rosner, and Dr. Michael Braun.

CHAIRWOMAN OLSON: Be seated at the front table when your name is called.

MR. MORADO: Please make sure you sign in.

Thank you.

DR. BRAUN: My comments were for the hospital, not the dialysis center.

MR. MORADO: That's okay.
CHAIRWOMAN OLSON: Just make sure you clarify that when you start speaking.

If everybody can do that, if you tell what project you're speaking on and if you're for or against the project, that would be really helpful.

And the first person can go ahead and start.

DR. ZAHID: Hi. Good morning.

I'm Dr. Mohammad Zahid. I'm a board-certified nephrologist at ARA, American Renal Associates, McHenry Dialysis Center, and I am here to oppose the establishment of yet another dialysis facility in McHenry.

The Dialysis Care Center of McHenry, which is Item H-06 on your agenda, is proposed to be located one minute away from McHenry Dialysis Center.

I would like to address two points: Number one, Planning Area 8 has a calculated need for two stations. That's misleading, I believe.

Planning Area 8 runs from Lake County to Kane County. The driving time from being in Lake County to Sugar Grove in Kane County is 1 1/2 hours.

As demonstrated, the need in the planning
area does not mean that there is a need in the McHenry area. Our facility, one minute away from the proposed site, is operating at 37.5 percent utilization. Another facility two minutes away from us is working at 42.9 percent of capacity. Patient access in the McHenry area is not an issue, and there is no need for an additional dialysis facility in the McHenry area.

Second, the application of another dialysis center in the last year has no track record of successfully opening or operating a dialysis center. As identified, innovation costs are only a small fraction of your standard and have identified equipment costs far below your standard.

Last, I mention that ARA facilities are operating at 30.2 percent of their capacity. Each of the nephrologists in the building and intend to admit patients have admitting privileges at our centers. 6 of our 37 patients are admitted by one of the four nephrologists, indicating a desire to use the proposed facility, again, only one minute away.

And lastly, I -- as I promised during our last CON application --
MR. ROATE: Two minutes.

DR. ZAHID: -- our -- 25 percent patients dialyze already. That's the reason for low capacity use.

CHAIRWOMAN OLSON: Thank you, Doctor.

Next.

MR. DILTS: My name is James Dilts, and I'm a divisional vice president for American Renal.

CHAIRWOMAN OLSON: Can you pull the mic closer, please?

Thank you.

MR. DILTS: My last name, Dilts, D, as in "David," -i-l-t-s.

ARA operates over 200 dialysis facilities nationwide, including three in Illinois. I'm here to oppose the establishment of another dialysis facility in McHenry.

McHenry already has two dialysis facilities, including ours, which is a one-minute drive away from the proposed new center which is Item H-06 on today's agenda. Members of the Board, I cannot imagine any reason to approve another dialysis facility in McHenry.

We operate with a medical -- with an open
medical staff, which means that any area
nephrologist can both refer patients to our facility
and follow their patients as acutely and as
accurately as they wish. We have been open for
five years, and our occupancy rate is currently
37.5 percent. If there's ever been a case of
unnecessary duplication of services, I believe this
is it.

Thank you for your attention.

CHAIRWOMAN OLSON: Thank you.

Next, Doctor.

DR. ROSNER: My name is Karol, K-a-r-o-l;
Rosner, R-o-s-n-e-r. I am a board-certified
nephrologist in McHenry, also raised in McHenry.

I'm also here to oppose the building of a
new dialysis unit, a third unit for our small town.

There is certainly, in my opinion, no need
for additional stations. Overcapacity in a very
specific field like nephrology or dialysis will
certainly raise a potential for hurting patients,
diluting the health care providers, and increasing
the stressors on all of those involved.

As of March 31st, just less than
three months ago, the unit that I have the majority
of my patients in runs at 40 -- just under
43 percent capacity, and, as was just mentioned,
ARA runs at 37 1/2 capacity. There are ample
additional stations available in the current --
where McHenry is at present.

There have been a total of 20 new end stage
renal disease starts, new dialysis starts, for our
group in the past five years. Again, that, to me,
does not justify creating and building a new
dialysis facility in our small town.

Contrary to one of the letters that supports
the unit, written by Dr. F. Bangash dated
December 26th of 2016, a quote, "extreme growth of
ESRD patients." Unfortunately, he has yet to start
even one patient in our unit. Again, his census in
our unit is zero. That, to me, does not support his
letter of support.

Additionally, another letter of support that
was written by Dr. F. Mohammadi supporting the
unit -- she no longer practices in the area. And,
to me, for somebody to walk away from a -- what is
an extreme number of ESRD patients is someone who
does not justify, again, a new unit being built.

Thank you.
CHAIRWOMAN OLSON: Thank you, Doctor.

Next.

DR. BRAUN: Okay. Good morning.

My name is Dr. Michael Braun. Thank you for allowing me to express my opinion about Mercy's proposed microhospital in Crystal Lake.

I'm a board-certified emergency physician and practice at Advocate Good Shepherd Hospital as well as the Good Shepherd urgent care in Crystal Lake. I'm here to oppose the project, as there is an abundance of emergency care services and immediate care services available in the Crystal Lake community.

One of the reasons Mercy states they're proposing this hospital is the citizens of Crystal Lake deserve access to emergency services. I think they're right. But the residents already have great access to four emergency departments within 20 minutes of the proposed sites. Two immediate cares, which are open 365 days a year, are also within five minutes. I'm concerned that the additional emergency department will just dilute the volume from the existing hospitals and immediate cares.
It also seems that Mercy's hospital will only take low-acuity patients. If a patient is transferred via ambulance and is having a stroke or a heart attack, Mercy will stabilize the patient and transfer them to another facility, which will waste time.

I'm worried that a hospital such as this will create confusion for the EMS providers. We don't want them to have to make decisions about which hospital is best for the patient in front of them. We want them to take the patient to the nearest hospital, knowing that the hospital will take great care of their patient and won't need to be transferred to another facility.

This hospital will not be a trauma hospital. It will have limited stroke capabilities, limited capabilities to take care of heart patients. This doesn't describe the access that Crystal Lake residents deserve.

I urge you to vote no on this project.

Thank you.

CHAIRWOMAN OLSON: Thank you, Doctor.

Next four, please, Juan.

MR. MORADO: Next four, we have the
Honorable James Glasgow, the Honorable Tim Baldermann, Karen Lambert, and Kevin Fitch.

Again, it's the Honorable James Glasgow, the Honorable Tim Baldermann, Karen Lambert, and Kevin Fitch. If you could please sign in, state and spell your name for the court reporter.

Thank you.

CHAIRWOMAN OLSON: We're missing two people. Are they coming to the table? They're not coming?

UNIDENTIFIED MALE: Mayor Baldermann will not be coming.

CHAIRWOMAN OLSON: That's one. Where's the other one?

(No response.)

CHAIRWOMAN OLSON: Last call. Okay. Two more.

MR. MORADO: Okay. Cheryl Vanderlaan and Ilene Steiner.

We can start with the folks that are here to speak on behalf of the Silver Cross project, and then we can move into the next project.

Thank you.

MR. GLASGOW: Good morning. My name is Jim Glasgow. I'm the State's attorney here in
Will County. I'm in my sixth term.

I've had the pleasure of working with Silver Cross Hospital going back to 1995, when we opened our Children's Advocacy Center. They were one of the first critical partners that allowed us to get the center open and so that we could treat our sexually abused children and effectively prosecute the predators who abused them. An officer said back then it was a godsend, that that facility was a godsend.

Well, this new hospital that US HealthVest intends to build here in Will County is another godsend. You all know that, when Tinley Park was closed, I testified at all those hearings, created a nightmare on the street for us. Our jail is now a mental hospital. I've got five specialty courts -- mental health, domestic violence, veterans court, drug court, Redeploy Illinois -- that all depend on these kinds of beds.

If you've seen the numbers for Will County, 700,000 people, we're an economically viable community. We've got CenterPoint. Things are booming, unlike in other parts of the state.

But as far as mental illness, we're in the
dregs. The number of beds per hundred thousand is woefully inadequate, as you have all seen from the statistics you've been given. This is critical to law enforcement. My job is to make sure that people aren't disobeying the law because they have a mental illness that, if it's controlled through our court system and through our treatment, they can live a law abiding life.

And when you look at the remedial costs and failure to fund treatment dollars like this, they're astronomical. You manage this individual, they -- the productive life, law abiding, and truthful. And otherwise they don't. So I would -- this isn't just a need. This is a moral imperative.

And I've got something framed in my office. It's a quote by John Kennedy, his statement to the chairman of the people forming the Peace Corps, and he's paraphrasing Dante's Inferno: "The hottest place is in hell, reserved for those who, in a time of moral crisis, maintain a neutrality."

We have a moral crisis in Will County right now, and neutrality is not acceptable, and I hope that you can see these numbers and look at this tremendous project. It's all -- all funded --
MR. ROATE: Two minutes.

MR. GLASGOW: -- no State dollars needed.

Please vote yes. Thank you.

CHAIRWOMAN OLSON: Thank you.

Next.

Is there another Silver Cross?

No? That's it for Silver Cross?

MR. GLASGOW: Yes.

CHAIRWOMAN OLSON: Okay. Thank you.

MR. MORADO: We can start with the next project.

MS. LAMBERT: Okay. Thank you.

Good morning, Chairman Olson and members of the Board. I'm Karen Lambert, president of Advocate Good Shepherd Hospital, and I appreciate the opportunity to be here today to share my concerns regarding the Crystal Lake Mercy Hospital project.

Our hospital has served the residents of Crystal Lake and its surrounding areas since we opened our doors over -- almost 40 years ago. We are about 6 miles from the proposed hospital.

The Mercy project before you is one that could set a major health care policy precedent. Approval of this project would essentially set a
precedent to establish new small hospitals in metro areas with existing hospitals and excess beds.

A primary purpose of the Planning Act is to foster systematic planning for health care facilities. One way for the Board to fulfill its purpose is to have predictable policies consistently applied. Board rules provide a benchmark.

I believe if you -- if you believe the microhospitals in metropolitan areas are appropriate and a new direction for health care policy, we'd suggest maybe changing -- an amendment to your rules.

As the staff's Board report shows, this report fails many of your review criteria. More importantly, the project provides no benefits that justify disregarding the Board's rules. This type of expensive project goes counter to health care cost reform, where we seek to serve patients outside of the hospitals and outside of emergency rooms.

Other speakers will come forward today to show you that, one, the project shifts hospital resources from Harvard, which is much more remote geographically and more challenged demographically; many of the patients projected to use the hospital
or emergency department actually live closer to full-service existing hospitals than the proposed hospital; the project is far too large and expensive; patients can obtain far more advanced emergency services at existing close-by hospitals, including two Level I trauma centers --

MR. ROATE: Two minutes.

MS. LAMBERT: -- within minutes of Crystal Lake and less expensive --

CHAIRWOMAN OLSON: Two minutes.

MS. LAMBERT: -- care at nearby immediate cares.

CHAIRWOMAN OLSON: Please conclude.

MS. LAMBERT: I ask -- thank you -- that you follow the rules and deny the project.

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next.

MS. STEINER: Good morning, Ms. --

CHAIRWOMAN OLSON: Just pull it closer.

MS. STEINER: Good morning, Ms. Olson, members of the Board.

My name is Ilene Steiner. I'm the planning manager at Advocate. Thanks for the opportunity to
share one of the reasons I think you should deny the Mercy Crystal Lake project.

As you may be aware, most of the hospitals across the country are facing declining revenue. That's declining resources to take care of our patients. Declines are being driven by lower payment rates by both private and public payers and by skyrocketing bad debt because our patients can't afford to pay their co-pays and deductibles.

Here in Illinois, the budget impasse has delayed State payments for Medicaid and State employment group insurance.

Of local interest, there was a recent Crain's article explaining that Advocate itself is reducing its budget by $200 million in order to get ahead of this financial problem. Another recent Crain's article reported the financial deficit that Centegra's facing.

In addition to these financial challenges, only one of the eight area hospitals within the 45-minute drive of the proposed site operates at the Board's target med/surg occupancy. The 18 surgery centers near the proposed site are operating at half the Board's target occupancy.
I share these facts because the Mercy -- the new Mercy Hospital will further adversely affect these area facilities already facing declining revenues and low occupancy.

The proposed service area for Mercy includes all of the communities in the Good Shepherd primary service area and most of the communities in the Advocate Sherman service area. The Mercy physicians are on staff at the area facilities, and their patients use the area hospitals.

So, yes, the Mercy Hospital will reduce volumes at facilities with already low occupancies and declining revenues and declining resources to take care of our patients.

This is one of the reasons I ask you to deny this project.

MR. ROATE: Two minutes.

CHAIRWOMAN OLSON: Thank you.

Next.

MS. VANDERLAAN: Good morning. I'm Cheryl Vanderlaan and I'm a physician strategy manager at Advocate Health Care.

I'm here to address Mercy's claim of a physician shortage in Crystal Lake and their concern
about the continuum of care and why a new hospital
would solve these purported problems.

The Health Resources Services Administration,
also known as HRSA, is a branch of the Department of
Health and Human Services and an important
organization that identifies geographies across the
country that are underserved.

According to HRSA, in 2016 there were
522 areas in the state of Illinois that were
designated as health professional shortage areas and
176 medically underserved areas in the state.
Crystal Lake was not one of these areas.

We do not need another hospital to attract
more physicians to the area. Physicians already
have a choice of four hospitals within 20 minutes
where they can send their patients and be seen.

Next, Mercy claims that it needs a hospital
to provide continuity of care for patients. As
medical staff members, Mercy physicians can already
access the full continuum of care for their
patients. There are many Mercy-employed physicians
who practice at an Advocate facility and are part of
Advocate's PHO and ACOs. In fact, two Mercy
physicians hold prominent leadership positions at
Advocate Good Shepherd in Barrington.

Just because there are Mercy physicians that admit to an Advocate facility does not mean that they lack the continuum of care when it comes to providing good patient care. Any physician on staff can follow their patients via Advocate's electronic medical record, reading images and writing orders for the patient without having to leave their office and even can do this in the comfort of their own home.

This ability to remain in touch with the patient is what continuum of care is all about. The full continuum of care at Advocate ranges from health management centers for chronic disease patients to open-heart surgery, which is not planned for in the Mercy microhospital.

In conclusion, there's no need for an influx of new physicians to Crystal Lake, and the continuum of care, indeed, exists between Advocate and Mercy.

I urge you to vote no on this project.

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next.

MR. FITCH: Good morning, ladies and
gentlemen of the Board. I'm Kevin Fitch, vice
president of finance for Advocate Sherman Hospital,
speaking in opposition to the Mercy Hospital
Crystal Lake.

You'll hear considerable testimony this
morning -- and we thank you for your time --
testimony in opposition, very detailed, specific
arguments. I'm going to recap some of the key
arguments that I think are important.

First off, the project does not meet
six important Board criteria. This is a much higher
number of negative findings than typically seen in
projects this Board approves.

Second, the project shifts resources from
the financially challenged and isolated community of
Harvard to the more affluent Crystal Lake community,
which is already well served by five hospitals.

Third, a new hospital is not needed in
Crystal Lake. The area is well served with five
hospitals, multiple immediate care centers, and an
ambulatory surgery center. There are five existing
area hospitals that already provide the services
that Mercy says are needed in geriatrics and chronic
disease management.
All five existing area hospitals also serve the medically indigent and provide higher levels of charity care than that provided at Mercy of Harvard, and all provide transportation services to enhance access.

Fourth, Mercy's claim that an emergency department is needed in Crystal Lake is unfounded. Most emergency patients will live closer to full-service hospitals than this location. And because the services of a microhospital are very limited, most life-threatening and critical patients will be transferred, which will delay care. And the less acute patients could be better cared for at lower-level immediate care centers at a lower cost.

Next, Mercy's claim of a physician shortage is unfounded, and Mercy's physicians do not need a new hospital for a continuum of care. They're already members of Advocate's physician-hospital organization and have access to coordinated system of care contracts.

Finally, by affording Mercy an acute care hospital license for what is primarily an outpatient facility, Mercy would be paid at higher rates costing the government --
MR. ROATE: Two minutes.

MR. FITCH: -- more money.

Please vote no.

CHAIRWOMAN OLSON: Thank you.

Next, Juan.

MR. MORADO: Next we have Trent Gordon, Colette Fraterrigo, Michael Ploszek, and Joe Ourth.

Again, that's Joe Ourth, Michael Ploszek, Colette Fraterrigo, and Trent Gordon.

CHAIRWOMAN OLSON: Somebody can go ahead and start.

MR. PLOSZEK: Good morning, everybody. My name is Mike Ploszek. I'm the vice president of physician strategy and operations at Advocate Good Shepherd Hospital.

Good Shepherd Hospital in Barrington is located 6 miles from the proposed Mercy site and, more importantly, it is a 12-minute drive from the proposed site.

I work closely with our physicians, and we have a number of Mercy physicians on our staff at Good Shepherd. Not only are they on our staff, but they are also in leadership positions at the hospital, including our accountable care
organization, our physician-hospital organization. We highly value our Mercy physicians. They are one of many independent groups that work at the hospital, and we certainly do not oppose the physician office building that has been proposed on that site.

However, I do very deeply oppose the hospital that is proposed for this site, and I want to address two of the reasons that Mercy has brought forward relative to building the hospital. And the two reasons are reasons that, quite frankly, you don't need a hospital. They can start right now.

First off, they want to establish a clinic to take care of patients with chronic health needs, such as diabetes and congestive heart failure. At Good Shepherd we're proud of our health management clinic, which does exactly this. We care for chronic disease patients with those symptoms and others. The purpose of this center is to keep patients out of the hospital and out of the emergency room.

Mercy could establish a clinic like this today in one of their existing outpatient centers without a hospital.
Next, Mercy states that they want to bring geriatric services to Crystal Lake, but they don't state why a hospital is necessary to provide geriatric services. We agree that it's important for patients to remain independent and healthy and out of the hospital.

MR. ROATE: Two minutes.

CHAIRWOMAN OLSON: Please conclude.

MR. PLOSZEK: Six million is a big amount when health care reimbursement is going down.

CHAIRWOMAN OLSON: Thank you.

MR. PLOSZEK: Thank you.

MS. FRATERRIGO: Members of the Board, I'm Colette Fraterrigo. I am the VP of finance at Good Shepherd Hospital.

The Mercy Hospital project will increase costs to patients, the community, Medicare, Medicaid, and I ask the Board to reject this application.

The project has an exceedingly high cost. The majority of the hospital space is designated for nonclinical functions such as administration, storage, support services, and not patient care.

This large allocation for nonclinical space is
highly unusual and not an economical plan.

Hospitals are expensive settings to care for outpatients. Most of the health care industry is lowering costs by moving services from the expensive hospital setting to the lower-cost sites of care, such as surgicenters, immediate care centers, and freestanding imaging centers.

Advocate Sherman recently received a CON permit to build a surgicenter with a charge structure that is one-third less than a hospital for the same set of procedures. This is a direct savings to the patient and the payer.

Advocate and major systems are offering low-cost options to the costly emergency department, such as immediate care centers, walk-in clinics, and extended physician hours. Mercy's plan to build a new hospital to serve primarily outpatients is in direct contrast to the industry moving outpatient services to lower cost settings.

You have heard of the term "hospital-based billing." The Centers for Medicare & Medicaid Services pays outpatient services at a higher rate when performed in a hospital rather than outside a hospital because it recognizes that hospital-based
care is more expensive.

As an example, the payment for frequent outpatient imaging tests is 50 percent higher in a hospital than the same tests in a nonhospital setting. Similarly, emergency care and surgery are paid at a higher rate in a hospital than in other settings.

By providing outpatient services in a hospital, Mercy would significantly raise rates for outpatient services.

MR. ROATE: Two minutes.

CHAIRWOMAN OLSON: Please conclude.

MS. FRATERRIGO: This, in turn, increases the cost to the patient, payer, and community. For those reasons, I ask the Board to deny this project.

CHAIRWOMAN OLSON: Thank you.

Next.

MR. OURTH: Good morning. I'm Joe Ourth, legal counsel for Advocate.

Today you're being asked to approve an expensive new hospital that deviates far from your rules. There's no need. Numerous hospitals are nearby, and the proposed hospital is nowhere near the hundred-bed minimum that your rules require.
Now, who could justify approving a project that deviates this far from that?

Mercy has said -- sometimes says, "Well, this is an innovative project," other times has said, "Oh, this is a common project. There's lots of small hospitals."

Well, it can't be both, but neither justify approval of this project. If innovative, the Board should change the rules to adopt a rule that allows hospitals of less than a hundred beds.

Alternatively, if it's something that's common and there are a number of other small hospitals to use as a model, this doesn't work, either.

At staff's request Mercy provided the Board with a list of small hospitals, 48 of them who are licensed for less than 25. Of those, on the average, there's only an average occupancy of 24 percent. Not a single small hospital meets target occupancy.

Are small hospitals universally bad? No, if they're in the right place. My home county in western Illinois has two stoplights and one 15-bed hospital. And they're glad they have it, but on an
average day, there's only three patients there the whole time.

    Now, when you see a small hospital, most of those, everything that's 25 and under is a critical-access hospital. A critical-access hospital is one that gets favorable reimbursement from the Federal government. Now, to qualify as a critical-access hospital, there's a requirement for that. You have to be 35 miles away from the nearest hospital. The hospital that's being proposed today, 6 miles is the closest one.

    Now, if you want to change this policy -- and this is a significant policy change -- then what you ought to do is adopt your rules.

    You --

    MR. ROATE: Two minutes.

    MR. OURTH: The Board frequently does that. And this would set a bad precedent, and we would ask that you vote no.

    CHAIRWOMAN OLSON: Thank you.

    Next.

    MR. GORDON: Good morning, Chairwoman Olson and members of the Board. My name is Trent Gordon. I'm the vice president of business development at
Advocate. I'm here to oppose the Mercy Hospital.

Part of my job at Advocate is actually to look at numbers and then to make sense of those numbers in a larger context. Having read Mercy's application for a new hospital, some things just don't add up. The application states that one of the purposes of this project is to provide care for the indigent population.

A study of demographics, however, showed that the community of Crystal Lake is actually a pretty affluent community in an affluent county. It is certainly much more affluent than Harvard, yet Mercy is proposing to shift services from lower-income Harvard to higher-income Crystal Lake.

This proposed new hospital will serve a lower percentage of Medicaid patients requiring inpatient services and does not offer the obstetric and pediatric services often needed by Medicaid patients.

I am concerned that Mercy will be leaving only five med/surg and ICU beds in financially challenged Harvard. Five beds is hardly a hospital. Mercy Harvard reported a peak census of 11 patients to the State, so where would the other 6 patients
go, then?

Mercy's history at Harvard further undercuts its claim that this project is to serve the indigent population. We pulled some COMPdata numbers and found that Centegra has more charity/Medicaid admissions from the city of Harvard than Mercy Harvard does. In fact, it's a lot more. In 2016 Centegra saw 260 Medicaid self-pay admissions from Harvard while Mercy saw only 29.

I certainly believe that Mercy will see some Medicaid and self-pay patients in Crystal Lake. Don't get me wrong. However, what they were telling you in their application that they will see and their experience of running a small hospital in Illinois are actually two very different things.

Finally, as Mr. Ourth pointed out, approving this project will result in the two smallest hospitals in the entire state of Illinois, the two smallest hospitals. The Board should consider if it's clinically appropriate to have a five-bed hospital --

MR. ROATE: Two minutes.

MR. GORDON: -- in the state --

CHAIRWOMAN OLSON: Please conclude.
MR. GORDON: -- and the precedence this may create.

Thank you for your time.

CHAIRWOMAN OLSON: Thank you.

Next.

MR. MORADO: Jeni Hallatt, Sue Schrieber, Ann Bunnell, and Ted Ducker -- Tim Aurand.

CHAIRWOMAN OLSON: Somebody can please begin.

MS. HALLATT: Sure.

I'm Jeni Hallatt, J-e-n-i H-a-l-l-a-t-t, vice president with Mercy Health.

We are requesting permission to redistribute 13 underutilized beds from Mercy Harvard Hospital to a responsibly sized small hospital we're proposing in Crystal Lake. We are not adding beds to the planning area but redistributing beds and doing what other health care providers are doing across the country in reconsidering facility design in order to meet today's technology, moving to outpatient care and decreasing reimbursement.

I'd first like to take a moment to clarify the cost breakdown of our project. Clinical construction costs for our 13 inpatient beds is a
total of $3.6 million. For the ED it's
2.25 million. For the surgical department,
6 million. And the diagnostic and treatment areas,
6.4 million.

There's $17.2 million for all the support
services in the facility. That's facilities,
dietary, medical records, cafeteria, pharmacy,
et cetera. And the remaining 44 million is for all
the land prep, the architectural fees, the
equipment, and a project of this size has multiple
millions of dollars in contingencies.

These costs are very much in line with
projects this Board has approved, and I noticed
there were recent approvals for a $4.6 million
fitness center for Kishwaukee and a $35.6 million
surgical center with only four operating rooms. The
most telling aspect is that the CON staff has
indicated our costs for this project meet the State
standards.

I also want to mention that the
representatives at Advocate had spoken of their --
the Medicaid that they serve. And that's great but
they didn't share the numbers.

Good -- excuse me. Advocate Good Shepherd
served 4.6 percent of Medicaid -- of their Medicaid population --

    MR. ROATE:  Two minutes.

    CHAIRWOMAN OLSON:  Please conclude.

    MS. HALLATT:  -- Mercy Harvard Hospital served 27 percent Medicaid.

    CHAIRWOMAN OLSON:  Thank you.

Next.

    MS. SCHRIEBER:  My name is Sue Schrieber, and I am the vice president of planning at Mercy Health.

    Planning Area A-10 has one of the highest outmigration percentages in Illinois. More than 55 percent of inpatients who live in McHenry County are treated at hospitals outside the county. In comparison, counties with multiple hospitals, such as Peoria and Sangamon County run about 5 percent outmigration.

    The services Mercy Health proposes at Crystal Lake are designed to fill the gaps as documented in the 2017 McHenry County community study. Mercy Health did not participate in this study, but we have read the study and know the results.
We do participate in health needs assessments for all the communities we serve including Harvard. We listen to the voices of the community and our patients and design programming that is in response to service gaps and community needs.

We know that cancer is the leading cause of death in McHenry County. Easy access to diagnostic services such as colonoscopy is key to early detection.

The study also identified mental health as a priority. Mercy Health has a long-standing commitment to providing mental health services in the communities we serve, and we will assess and work to meet the needs of individuals living in Crystal Lake.

Finally, in the county health community study and focus groups, community leaders noted certain overarching issues, including a lack of continuity of care for chronic conditions, limited access to physicians for Medicaid patients, availability and accessibility of public transportation.

The new Mercy facility is designed to fill
service gaps and meet community needs. Our opponents would have you believe there are absolutely no service gaps in McHenry County. Clearly, gaps exist. We urge you to support this innovative project and do the right thing for the citizens of Crystal Lake.

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next.

MS. BUNNELL: Hi. I'm Ann Bunnell, senior manager for the Mercy Health behavioral health services. I'm speaking in support of Mercy Health's project.

Mercy Health has a long-standing commitment to providing behavioral health services in the communities we serve. We currently offer comprehensive behavioral health programs in Janesville and Rockford. These services include a continuum of hospital-based inpatient mental health and detox services, day treatment services for children, adolescents, and adults, as well as addiction adult day treatment services.

Additionally, we offer outpatient mental
health and addictions services in many of our
communities with over 50 treating counselors,
therapists, nurse-practitioners, and psychiatrists.
We have continued to expand our services as needs
dictate.

The McHenry County Healthy Community Study
identified mental health as a priority. At our
Crystal Lake facility, we're looking forward to
establishing outpatient behavioral health services
at our medical office site. Once the clinic is
operating, we will take our guidance from McHenry
County's outstanding board of health that helps
guide 27 agencies in the county already.

Given our long-standing track record in
providing mental health services, we look forward to
meeting the needs of Crystal Lake residents and will
work to that end.

CHAIRWOMAN OLSON: Thank you.

DR. AURAND: Good morning. I'm Tim Aurand,
the James E. Thompson professor of marketing at
Northern Illinois University.

The study I'll report on was conducted by
faculty and students at Purdue University. It's a
community survey done to assess residents living in
the Crystal Lake region regarding their views on the need for emergency department services in Crystal Lake. Specifically those residents in the primary service area were the main focus, which includes the communities of Crystal Lake, Cary, Algonquin, Lake in the Hills, and Fox River Grove.

Three survey methods were used with a total of 396 respondents. Survey size and time were appropriate for each report.

Over 93 percent of people in the primary serve area believe it is very important to have an emergency department close to their home. When we looked at age in consideration, results showed that, as age increases, their definition of "close" became very evident. Those respondents aged 55 years or older reported the need for an emergency department 2 1/2 miles closer than younger respondents, indicating current emergency department service were too far away by miles as well as by drive time minutes. They were acutely aware of the need to access care quickly.

For residents who indicated they had difficulty accessing emergency services, the respondents were asked to explain what location they
were trying to reach. Problem locations too far
away included Sherman Hospital, NIMC McHenry,
Centegra, Lutheran Geneva, Good Shepherd,
St. Alexius, and Advocate Christ.

With regard to difficulty in reaching an
emergency department, comments such as "Due to
Saturday traffic on Randall Road; it was a long
drive even though it was in the middle of the
night." That was a 65-year-old female trying to
reach Good Shepherd.

Also, 52.2 percent reported increased
difficulty in reaching the nearest emergency
department in rush hour traffic. The need for
emergency department services in our community rose
significantly and geographically.

65.4 percent of respondents from
Crystal Lake indicated there was a significant need
for emergency department services --

MR. ROATE: Two minutes.

DR. AURAND: -- in Crystal Lake.

CHAIRWOMAN OLSON: Please conclude.

DR. AURAND: Okay.

This was a direct response to the statement:

"I feel there is a need for the emergency department
in Crystal Lake."

CHAIRWOMAN OLSON: Thank you.

MR. MORADO: Next up we have Michael Eesley, Aaron Shepley, Hadley Streng, and David Tomlinson.

Please, if you have written comments, can you make sure you get them to Mr. Constantino when you're done speaking?

Thank you.

CHAIRWOMAN OLSON: Please go ahead.

MR. TOMLINSON: Okay. Good afternoon. My name is David Tomlinson, and I'm speaking in opposition to Project 17-002.

I serve as the chief financial officer at Centegra Health System, and this project will negatively affect area hospitals, including Centegra Health System's existing hospitals in Huntley, McHenry, and Woodstock. Mercy itself acknowledged this in its application.

Just 10 months ago we opened Centegra Hospital-Huntley, which, according to the State rules, still has two full fiscal years to meet target occupancy standards. If another facility is constructed less than 9 miles away, the volume projections and analysis that went into the creation
of Centegra Hospital-Huntley would be in vain. Our ability to serve patients would clearly be compromised.

In its application Mercy states that a hundred percent of the hospital's volumes would be made up by diverting patients from each of the five surrounding acute hospitals, an average of 156 patients per hospital. This is only shifting volume from existing hospitals to their proposed facility, which does not create value; rather, duplication.

In addition, Mercy projects 17,000 emergency department visits in the first year of operations at this new facility. Using these numbers, this means every hospital in the planning area would lose about 3400 emergency department visits to Mercy. This is a significant loss in volume and would result in about a 15 percent loss in volume at Centegra Health System.

Mercy's project does not add value, cost savings, or enhanced services for the patients of our community. It simply shifts volumes away from the five existing hospitals with no added benefits to the patients.
Thank you. Please vote no.

CHAIRWOMAN OLSON: Thank you.

Next.

MR. EESLEY: Good afternoon. I'm Mike Eesley, CEO of Centegra Health System. Chairwoman Olson and members of the Board, thank you for allowing us this opportunity.

We service -- our hospitals service McHenry, Kane, and Lake Counties in Illinois. It is most important that we keep our focus on the needs of our patients and their families. Patients are wanting high-quality local care. Our region already has five nearby hospitals that provide this service.

Our community is already experiencing changes as a result of major shifts in the health care industry. The Affordable Care Act made more people eligible for government-sponsored health plans that they cannot afford.

Patients are suffering from a burden of high-deductible health insurance and we're also seeing the same kind of outcomes within our health systems. We are receiving lower reimbursements, more than ever, for the leading care that we provide.
In 2010 this Board projected a bed need in McHenry County for medical/surgical, obstetrics, and intensive care beds. At the time the medical/surgical need was 83, and that was when we were proposing to build Centegra Hospital-Huntley.

Just a year later the State revised the region's medical/surgical bed need to be even greater, to be 138 beds, and Centegra Huntley Hospital was approved by this Board.

Since that time our community's projected growth has flattened. The State again revised the bed need to reflect that trend. Like every other responsible health care system in the state, we must reevaluate where and how we provide services to our patients. We must become more efficient so that we can continue to care for our community.

As we have more than 100 years of service, Centegra Health System will continue to adjust services to address the needs of the patients we serve. Our community does not need another hospital.

Please deny this project.

MR. ROATE: Two minutes.

CHAIRWOMAN OLSON: Thank you.
Next.

MS. STRENG: Good afternoon.

My name is Hadley Streng, and I'm senior vice president of strategy and development for Centegra Health System. I am here in opposition to Mercy Health's project, 17-002.

Mercy Health is proposing to establish a microhospital; however, the proposed project does not meet the commonly recognized characteristics of a microhospital.

The Advisory Board Company is one of the most respected health care consulting firms and describes the design and purpose of microhospitals as follows: Beds, typically 8 to 10. Mercy Health's proposal is 13. Cost, usually ranges between $7 million and $30 million. Mercy Health revised theirs to be just under $80 million, over $6 million a bed.

Size, typically 15,000 to 50,000 square feet. Mercy Health's proposal is 111,000 square feet. The average general hospital across the country is only 75,000 square feet.

Purpose, to fill in service gaps in areas lacking inpatient facilities. There are five
hospitals within 12 1/2 miles of their proposed site. There's not a lack of service. Mercy Health's proposed microhospital is not micro in size, not micro in cost, and not micro in purpose. This project does not meet the Review Board's criteria and should be denied.

   Thank you.

   CHAIRWOMAN OLSON: Thank you.
   Next.

   MR. SHEPLEY: My name is Aaron Shepley, and I'm here today as the general counsel for Centegra Health System.

   My family moved to Crystal Lake 45 years ago, and for the last 18 years I've also served as the mayor of Crystal Lake.

   I'm opposed to Mercy Health System's proposed project in Crystal Lake. In the simplest terms, this proposal is nothing more than a ploy designed to allow Mercy to do what Illinois Courts and this Board have rejected at least four times.

   Mercy packages this project as a 13-bed microhospital, a, quote, "new" type of hospital that has received little support in the United States, has never been approved or constructed in Illinois,
and, in fact, is not even permitted under the Planning Act.

A review of the size and scope of this project reveals that it bears a striking resemblance to Mercy's failed projects of the past. In 2004 Mercy presented a proposal for a 70-bed facility with 160,000 square feet and a cost of $81 million. In 2011 the proposal was 162,000 square feet and cost $115 million. In both proposals well over half the space was reserved for clinical activities.

Today Mercy is proposing a 111,000-square-foot, 13-bed hospital at a cost of $79 million with well under half the space reserved for clinical activities.

Significantly, Mercy filed a separate application for a 40,000-square-foot MOB that is not merely interdependent with the hospital; it will be the top two floors of the hospital and will share an open two-story atrium.

The most likely explanation for the separate applications is that, had Mercy combined the applications as required by planning standards, the total size of the project would be 151,000 square feet, nearly identical to the rejected 70-bed
proposals.

If approved, Mercy would arguably have the ability to systematically add beds and incrementally convert nonclinical space to clinical without any further approval from this Board.

This ploy should be rejected and Mercy's application denied.

CHAIRWOMAN OLSON: Thank you.

Next, four more.

MR. MORADO: James Adamson, Dan Lawler, Matthew Wilson [sic], and John Cook.

CHAIRWOMAN OLSON: Please, somebody, go ahead and start.

MR. COOK: I'd be happy to start. My name is John Cook. I'm chief financial officer of Mercy Health. I would like to comment on the financial viability of Mercy Health's proposed hospital in Crystal Lake.

Mercy Health has a long history of achieving the highest quality at an affordable cost. This is due to our integrated care model as confirmed by attainment of the Malcolm Baldrige Award, which Mr. Bea will talk about in his presentation.

Each of our hospitals and clinics are
expected to meet national benchmarks for quality and cost. Over the last 10 years, operating income as a percent of revenue has averaged over 3 percent annually for Mercy Health. Mercy Health has realized revenue growth and positive operating income every fiscal year.

When Mercy Health acquired the nearly bankrupt Harvard Hospital, we invested over $26 million in the facility, turned around the operation, and brought high-quality health care to the residents of Harvard.

The Harvard Hospital has averaged a 5.5 percent operating margin even though 27 percent of its enrollees -- or patients are enrolled in Medicare.

Mercy Health has the fiscal discipline needed to make strategic decisions that generate a reasonable return on investment. This is due to great planning and execution of its strategic plans.

As with all of our projects, including our merger with Rockford Health System and the Rockford CON applications approves by this Board, Mercy Health engages in stringent financial modeling as to construction and operating costs.
Our proposed Crystal Lake projects have been vetted and will achieve profitability within three years from opening and an 8 percent return on investment.

While other systems have announced massive cost-cutting initiatives or are merging with large regional hospital systems, Mercy Health has been quietly reducing costs and improving quality metrics. To be financially sustainable, health systems need to deliver high quality and low cost, and that's exactly what the Crystal Lake project is designed to do.

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next.

MR. WATSON: Good afternoon.

My name is Matthew Watson, and I'm the regional director of operations for OrthoIllinois, an independent group of 33 physicians, and we serve Crystal Lake, McHenry County, and the Rockford metro area. I'd like to give you my opinion about the proposed Mercy Crystal Lake hospital.

Neither our physicians nor our staff are employed by a health system, so I think that we
bring a unique perspective for this debate. As a private orthopedic group, we believe that there are plenty of services in the Crystal Lake area when it comes to physician access to patients, emergency services for patients, and hospital beds for patients.

We don't think it would be a benefit for our patients nor our physicians if another hospital were to open in McHenry County. The only group that would benefit from the hospital would be Mercy. Should they open up a medical office building and hospital, they would be able to charge higher rates for their outpatient ancillary services, such as MRIs and X-rays, than if they opened such services in a clinic.

For example, my group, we own an MRI and X-ray, but because we're not in a hospital setting, we only charge provider-based rates. The hospitals can charge hospital-based rates, which are much higher and -- at least the base rates -- and this means much higher payments to Mercy from government payers, private payers, and from patients.

While this is a small hospital, it will mean big bills for patients. That's not what we want for
the patients in our community there.

Finally, health care resources are scarce these days for health systems, hospitals, and physicians. As you may be aware from a recent Crain's article, Centegra's losing $40 million after opening their new hospital in Huntley. This should be a cautionary tale and should aid you in making your decision.

As I read the application, I saw that Mercy's volume to fill these hospital beds would directly come from other systems, including Centegra.

In conclusion, I know that you'll hear from several health care systems today. Please also hear what private independent physicians are saying. We're saying "Please, no" to Mercy's hospital project.

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next.

MR. ADAMSON: This is a statement in opposition to the Mercy Crystal Lake project, 17-002. My name is Jim Adamson. I'm the director of risk and regulatory matters for Centegra Health.
There's ample competition among health care providers in the McHenry County planning area. We know this because whenever Centegra has tried to add or expand services, there has been opposition by at least five different hospitals and health systems to it. They only do that because they are aggressively competing for patients in McHenry County; however, all this competition in the planning area does not create the typical free market benefits.

Mercy Health's vice president Jennifer Hall recently said at a Review Board public hearing just a few weeks ago, "This is not a free market situation in which placing a Walgreens next to a CVS is better for the consumer." Indeed, the economics of health care are different. Opening a hospital next to an existing one does not, in fact, make it better for the patients.

Large consumers such as Medicare and Medicaid dictate their own prices, frequently below the cost of the services being provided. Additionally, various governmental requirements for free or discounted care, such as EMTALA, further
stress providers. These realities are not part of the regular free market.

In recognition of the unusual economics of health care delivery, the Illinois legislature has tasked the Review Board with assuring the proper allocation of services so as not to create unnecessary duplication of services and maldistribution of services.

The primary danger of unnecessary duplication and maldistribution is that it reduces utilization at existing facilities and reduces margins that are already razor thin, thereby destabilizing the entire health delivery system.

This Board has no obligation to protect Centegra's market share or Advocate's market share; however, the Board does have an obligation under the Planning Act to establish an orderly and comprehensive health care delivery system that guarantees the availability of quality health care to the general public.

The Planning Act is designed to promote the orderly and economical development of health care facilities in the state of Illinois that avoids unnecessary duplication of such facilities.
Mercy Crystal Lake Project 17-002 is an unnecessary duplication of --

MR. ROATE: Two minutes.

MR. ADAMSON: -- facilities. It will undermine the --

CHAIRWOMAN OLSON: Please conclude.

MR. ADAMSON: -- comprehensive health care delivery system.

CHAIRWOMAN OLSON: Thank you.

Next.

MR. LAWLER: My name is Dan Lawler. I'm a partner with the law firm of Barnes & Thornburg and here to oppose the Mercy Crystal Lake Hospital.

Mercy describes its microhospital as a new model of health care delivery. I agree with that and the State has an interest in promoting new models of health care. That is why we have the Alternative Health Care Delivery Act.

Under that act a new model of care is first researched by the State Board of Health, recommended to the Governor and the General Assembly by the Department of Public Health, and enacted into law. Only then are these new models in care subject to review by this Board under criteria specifically
adopted for that particular model. That was the
process for birthing centers, residential rehab
centers, and other new models of care that this
Board has been empowered by the General Assembly to
review.

Were this Board to proceed on its own
without the State Board of Health and Public Health
and the Governor and the General Assembly and absent
criteria for microhospitals, it would still have to
find substantial compliance with criteria that are
available.

What is substantial compliance with a rule
that requires 100 medical/surgical beds? Is it 90?
80 beds? 70? The Board has discretion but at some
point there can be an abuse of discretion. Where is
that point?

The Circuit Court of Illinois has held that
approval of a 56-bed unit when a rule requires
100 is an abuse of discretion. I litigated that
case. If 56 beds is not substantial compliance and
transgresses the bounds of proper discretion, what
does that say about 11 med/surg beds when the rule
requires 100?

Thank you.
CHAIRWOMAN OLSON: Thank you.

Next four.

MR. MORADO: John Hanley, Matthew Sanders, Dr. John Dorsey, and Pat Cranley.

CHAIRWOMAN OLSON: Please go ahead.

MR. SANDERS: Hi. My name is --

THE COURT REPORTER: Wait. I can't hear you.

CHAIRWOMAN OLSON: Pull the mic toward you.

THE COURT REPORTER: Would you start over again. I didn't hear your name. Sorry.

MS. AVERY: You still need to bring it very close.

CHAIRWOMAN OLSON: Use your outside voice.

MR. SANDERS: Okay. My name is Matthew Sanders, and I am a licensed architect with AECOM, a national health care design firm representing Mercy Health. I have worked on health care projects for more than 25 years.

There have been references made to microhospitals built elsewhere throughout the country. The cited examples are stripped-down microhospitals built by developers. One facility is not even a hospital; it's a stripped-down ER. These
are inaccurate projects to compare, considering the differences in program and location.

These facilities are leased. They are not owned like Mercy Health would be owned. Components of the cost are not being accurately captured. The true cost of construction is obscured.

There are significant program differences, as well. Surgery, in many cases, is not included. Imaging services are limited. Outside food services are used versus a full cafeteria service model. Support services like central sterile are outsourced and not provided on campus.

These facilities operate like an outpatient clinic. Their nursing units are designed similar to observation units with double-occupancy patient rooms, which would not be competitive in this market. These facilities would not even meet the IDPH standards.

In terms of costs and sites, you should consider more appropriate comparisons to the Mercy Health facility project. Kirby Hospital in Monticello, approved for $34 million in 2009 with one-third less square footage equates to, today's dollars, about $68.3 million.
The proposed abandoned expansion of Centegra-Woodstock Hospital was proposed in 2008 and approved for $52 million. It would be $77 million in today's dollars, almost the same cost as this proposed project.

Lurie Children's outpatient facility in Northbrook was recently approved by this committee for $35 million. It is only 36,000 square feet, one-third the size of Crystal Lake. It is over a thousand dollars per square foot.

So, in summary, the Mercy Health Crystal Lake proposed project is appropriately programmed, and the cost is in alignment with the current market and meets the State standards.

Similar projects --

MR. ROATE: Two minutes.

MR. SANDERS: -- as Crystal Lake's have been approved by the State in the past.

Thank you.

CHAIRWOMAN OLSON: Please conclude --

thank you.

Next.

DR. DORSEY: Good morning. I'm Dr. John Dorsey, D-o-r-s-e-y, vice president of physician
services and CMO at Mercy Health.

I am here not only to express my support for the Mercy Health project but also to explain our vision of care delivery at this facility. The combination of an emergency department, ambulatory facility, and 13 inpatient beds affords our patients convenience, flexibility, and efficiency.

Consider this facility as a first line of medical defense for the 50,000 people of Crystal Lake. We believe in delivering the right care at the right location at the right price, and this project achieves these goals.

We envision in our ambulatory facility that patients will be able to easily access more than one provider on the same day, as these providers will all be under the same roof. This minimizes return visits, delays in diagnosis and treatment, and this concept of coordinated care is especially important for the elderly, ill, and the economically challenged citizens of Crystal Lake.

When a patient presents to the ED, they will be triaged. If their clinical needs fall in the immediate care category, we will have primary care providers with extended hours available to treat
If the triaged patient needs ED care, this will be delivered by board-certified ED docs with the goal of 15-minute wait times in an efficient manner. And this also, in our layout, will allow privacy for those individuals presenting with such things as acute mental health needs, potential victims of physical or sexual violence.

Once evaluated and stabilized, patients may be discharged home, they may be transferred to one of the comprehensive hospitals already existing in the area, or kept overnight for observation in one of our 13 inpatient beds. Sometimes these extra hours in a bed are necessary to further treat and evaluate the patients and, again, particularly important for the elderly and vulnerable. These 13 beds will provide safe and efficient care --

MR. ROATE: Two minutes.

DR. DORSEY: -- for those needing a longer period of observation --

CHAIRWOMAN OLSON: Please conclude.

DR. DORSEY: -- than can be done in an emergency department.

Thank you.
CHAIRWOMAN OLSON: Thank you, Doctor.

Next.

MR. HANLEY: Hi. I am John Hanley, head of health care investment banking at Ziegler, a health care specialty investment bank celebrating 115 years of operation in Illinois.

I work with health systems in states with and without the certificate of need process. In many situations I find those who oppose projects selfishly look to protect their market share while ignoring the optimum model of care to best serve patients.

I support Mercy Health's 13-bed hospital and medical clinic for several reasons. First, health care is local; it is not the relative size of an organization, measured by gross or net patient revenue, but its size relative to its market. The building of a campus which includes a small hospital will accomplish these goals for Mercy Health, which has, for decades, provided the Crystal Lake market with quality health care.

Failing to implement appropriate size and scale often results in financial pressures to an entity, as we have seen at many facilities across
the country, in the state of Illinois, and even
locally with Centegra and their significant losses
over the last two years.

Second, management matters. I've seen the
strength of Mercy Health's senior management team,
led by Javon Bea, tackle challenges head-on. The
latest examples include the uniting of two systems,
Mercy Alliance and Rockford Health System in their
affiliation and the tremendous financial turnaround
of Rockford Health. Mercy Health enjoys a strong
rating by Moody's Investors Service and Fitch.

And as to the opposition comments that this
project cannot be financially viable, they're simply
not true. Ziegler has analyzed 44 hospitals in the
state of Illinois that are 25 beds and under and
8 that are 50 beds and under. 50 percent of those
hospitals have positive operating margins.

My conclusion is that small hospitals can be
and are viable. It all comes down to the management
of these smaller hospitals and the ability to
appropriately provide care to the patient population
they serve in the right setting.

MR. ROATE: Two minutes.

MR. HANLEY: Mercy management --
CHAIRWOMAN OLSON: Please conclude.

MR. HANLEY: -- has proven to be exceptionally strong in these categories. And I --

CHAIRWOMAN OLSON: Thank you.

MR. HANLEY: -- recommend the Board approve the project.

CHAIRWOMAN OLSON: Thank you.

Next.

MR. CRANLEY: Madam Chair, members of the Board, my name is Patrick, P-a-t-r-i-c-k; Cranley, C-r-a-n-l-e-y. I am senior vice present and chief operating officer of Mercy Care Health Plans.

Mercy Health is both vertically and horizontally integrated as a health system. Mercy Health has operated its own health plan since 1996.

While "population health management" has become kind of a buzzword these days, Mercy Health has long-term experience managing the cost and health of our patient population.

Mercy Health's approach to population health and our integrated care models ensure the cost-effective use of premium dollars. This results in extremely low and competitive premium prices for employers and employees and permits the deployment
of greater resources in caring for patients.

   In Wisconsin MercyCare offers a variety of plans, including individual and family plans, senior supplement plans, a Medicaid MCO, and commercial HMO and PPO plans.

   Last year MercyCare made national news as the only company in Wisconsin to lower our rates on the Wisconsin Health Insurance Exchange, which provides affordable care under the ACA to low- and middle-income families.

   Last year MercyCare also began offering our HMO products in the Illinois counties of Boone and Winnebago. We hope to bring our health insurance offerings to McHenry County, as well. Unfortunately, that will not be possible without the ability to also fully implement our integrated care model.

   In order to manage the full spectrum of care and provide care coordination, Mercy Health's patients must have access to the full spectrum of health care services, including hospital care.

   Today, a single hospital system, Centegra, controls 95 percent of all the beds in McHenry County.

   Based on my 20 years in managed care, most of it devoted to negotiating with hospital systems,
I can assure you that that's a recipe for increasing prices and decreased choices for consumers.

  MR. ROATE:  Two minutes.

  CHAIRWOMAN OLSON:  Please conclude.

  MR. CRANLEY:  Where there is no competition in a market for health care services, payers --

  CHAIRWOMAN OLSON:  Please conclude.

  MR. CRANLEY:  -- have no choice but to meet the demands of the providers.

  CHAIRWOMAN OLSON:  Thank you.

  MR. CRANLEY:  Thank you.

  MR. MORADO:  Next up we have Ladd Udy, Michael Hill, Mark Kownick, and Jen Hall.

That's Ladd Udy, Michael Hill, Mark Kownick, and Jen Hall.

  CHAIRWOMAN OLSON:  Please go ahead.

  MR. UDY:  Good morning. My name is Ladd Udy, L-a-d-d U-d-y. I'm the director of population health for Mercy Health, and I'm here to share with you just two data points that demonstrate why I support the Mercy Health project.

One of the strongest levers in the population health movement away from paying for volume but paying for value instead in health care
is called accountable care. You've heard that term today. This is a new way of contracting in which Medicare and other insurers measure us on quality and on the total cost of health care.

It so happens that Mercy Health, Centegra, and Advocate are all part of the same accountable care program, Medicare Shared Savings Program, so this is the best apples-to-apples comparison of overall value delivery we have.

I'll review the results with you from 2015, which is the most recent year we have data for.

Here's how the quality scores came in, from high to low on a 100-point scale: Mercy Health at 97.97, Advocate at 94.19, and Centegra added up to 89.82.

On the flip side, here's what Medicare spent per patient per year in 2015, again from high to low: Advocate at $10,909 per patient, Centegra at $10,438, and Mercy Health at $8,773 per patient.

So of the three main competitors in McHenry County, Mercy Health had the highest quality and by far the lowest spend. And what that means is that, if all Medicare patients assigned to any of the ACOs in McHenry County would have received their care at the Mercy Health cost rate, it would have saved
Medicare over $67 million just in 2015.

And on a larger scale, let's say all of Advocate's assigned Medicare patients across their footprint had received their care at the Mercy Health cost rate. That would have saved Medicare over $320 million in one year alone. And those are the savings for Medicare only, so the potential for total savings are enormous with all patients within the Mercy Health model.

But we're missing one piece in McHenry County in order to deliver that full spectrum of care so our patients have to go to our competitors for those services, where it ends up costing more.

The residents of Crystal Lake deserve better, and they clearly want a better option. The objective data show that Mercy Health is that better option for delivering value.

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next.

MR. HILL: Good afternoon.

Good afternoon. I'm Michael Hill. I'm the public health administrator for McHenry County.

CHAIRWOMAN OLSON: I need you to speak right
into the microphone, please.

MR. HILL: I'm having allergy problems today. Is that better?

CHAIRWOMAN OLSON: Yes.

MR. HILL: I'm Michael Hill. I'm the public health administrator for McHenry County, Illinois. I'm here to express my strong support of the two Mercy Health certificate of need requests seeking approval to build a multispecialty clinic and 13-bed hospital in Crystal Lake, Illinois.

Our health department is charged with using evidence-based research to address priority health concerns in our community. Our needs assessments have confirmed that more than 65 percent of McHenry County residents seek care outside of McHenry County. This is an unfortunately high percentage.

It is also a significant and unfair burden on disadvantaged populations, including the indigent, elderly, and those with limited access to reliable transportation, populations that are traditionally underserved and forgotten.

Mercy Health's proposed projects would bring vital new resources to the Crystal Lake community
that would improve the level of access to care to this group in particular. Mercy Health has already demonstrated its commitment to serving the underserved in the markets where they currently provide health care. This measured proposal is not seeking to increase the licensed beds but, rather, to redistribute beds to where they are most needed. Allowing them to further their mission in Crystal Lake is both critical and responsible.

Mercy Health’s proposed projects will also provide for the first-ever emergency department in Crystal Lake. Again, from a public health perspective, at-risk populations in Crystal Lake have suffered from lack of adequate emergency care provided locally. This contributes to poor health and skyrocketing health care costs.

The Crystal Lake area is a growing community of 60,000-plus. It is large enough to need and support an emergency department and a small hospital. The proposal directly addresses the health needs and priorities identified in the 2017 Healthy Community Study. We would all benefit significantly. How can you say no to increased efficiency, reduced cost, and better care for our
For these reasons I respectfully request that the Illinois Health Facilities and Services Board approve Mercy Health's certificate of need proposals.

CHAIRWOMAN OLSON: Thank you.

Next.

MR. KOWNICK: Madam Chair, Board members, my name is Mark Kownick. I'm the mayor of the Village of Cary.

On behalf of the Village, I am here to express our support for Mercy's proposed hospital and medical office building at the intersection of Route 31 and Three Oaks Road in Crystal Lake. The proposed project would be located approximately one-half mile west of Cary's corporate boundary and would provide our residents with an important resource that would easily be accessible.

This is especially attractive for two reasons, the first being expanding access to vital health care services close to home increases convenience and encourages residents to seek care on a proactive basis, when it's least expensive.

Secondly, adding an option for emergency
care close to home is a great benefit for every resident in our area and, for some in particular, it would be a significant improvement to the quality of life.

Our goals as a Village include supporting the development of services that benefit our growing senior population. That population, in particular, has long needed and desired a local emergency department. This fills an existing gap in a long--and is long overdue.

We also appreciate how the proposal is structured in such a thoughtful manner, delivering services where and when without overdelivering. It is an appropriate use of resources.

I understand the emergency department will be classified as comprehensive, the highest classification conferred by Illinois. This means that it will be able to cover approximately 97 percent of all emergency needs, which are currently not being met locally. This is a significant and positive change with the power to improve the lives for all Cary residents.

Additionally, the new hospital is proposed along two major roadways in the most densely
populated part of the McHenry County, with Three Oaks Road providing direct and convenient access from Cary and other communities along US Route 14 to the east. This means that the large majority of McHenry County residents would have increased access to quality care, a benefit for all of us.

The Village is highly supportive of this proposed project and the benefits it would have for the entire region. The Village recommends approval of Mercy Health Care's application.

CHAIRWOMAN OLSON: Thank you.

Next.

MS. HALL: Good morning. My name is Jennifer Hall. I'm the vice president of government relations and community advocacy for Mercy Health.

While I appreciate that our opponents are paying attention to what I say in the press, I'd just like to put the quote that they just made for me into context when I stated I was talking about this is not a free market situation and it's not like putting a Walgreens and CVS next to each other.

That has nothing to do with Crystal Lake. It was in regards to highly specialized services in a Level III NICU.
Our opponents would have you believe that the residents in McHenry County are different, are affluent, and that they own or have access to a car, which is often not the case. There is a significant working class who struggles to afford medical care and a growing charity population.

In fact, Crain's Chicago Business reported that Centegra lost at least 30 million so far this year, and I quote, "Centegra executives blamed the bleeding partly on being stiffed by patients who won't pay or can't afford the medical bills, not on the health system not being able to fill its new hospital."

According to the McHenry Healthy Community Study which our opponents developed, McHenry County has a total population of 49,938 Medicaid enrollees, representing 16 percent of the County's total population. This population is growing, evidenced by the 6.2 percent increase since 2006.

The Healthy Community Study identified access to health care for Medicaid recipients as a major problem in McHenry. Community leaders identified physicians in the area limiting the number of Medicaid patients they will accept as one
of the most troublesome issues. 14.7 percent of those responding stated that they did not receive medical care because they could not find a provider who accepted Medicaid.

Mercy Health's Crystal Lake hospital will help alleviate this pressing issue. Mercy Health is dedicated to serving charity populations. Mercy Health's Harvard's Medicaid population is 27 percent of the patients served.

MR. ROATE: Two minutes.

CHAIRWOMAN OLSON: Please conclude.

MS. HALL: This exceeds Centegra-Woodstock at 3.9, Centegra-McHenry at 3.6, and Advocate Good Shepherd at 6.4.

CHAIRWOMAN OLSON: Thank you.

MS. HALL: Thank you.

MR. MORADO: Next up we have Dr. Joseph Fojtik, Dr. Emily Shen, Dr. Doug Henning, and Mariann Vieweg.

Dr. Joseph Fojtik, Dr. Emily Shen, Dr. Doug Henning, and Mariann Vieweg.

CHAIRWOMAN OLSON: Who are we missing?

MR. MORADO: One more, Tom Jensen.

CHAIRWOMAN OLSON: Somebody can please
begin.

DR. FOJTIK: I'll go. My name is Joseph Fojtik, F-o-j-t-i-k. Good afternoon. I'm a general internist and I have been in practice for 28 years in the state of Illinois, 20 of them with Mercy Health.

I'm here in strong support of Mercy Health's small hospital and clinic proposals. There is an ongoing and necessary transformation in the health care delivery system that we are now going through as a country, both regionally and nationally.

Part of this transformation will require the so-called improvement of the triple aim, where we try to improve the overall experience of the patient, decreasing costs, and try to improve the entire health of patient populations.

This will, in the next step, necessarily try to improve the coordinations of care between clinicians and also try to improve how we communicate to each other with our clinical data. The truth is, when patients are in a single system and they have the same electronic medical record system between the clinicians and the hospitals, the standard transformation occurs much more readily and
much more safely.

    So, for example, recently one of my patients was admitted to a local hospital. The patient had significant shortness of breath, and the pulmonologist thought the patient had an active heart condition. He ordered the patient an echocardiogram, an ultrasound of the heart.

    The patient saw me three weeks later, still very short of breath, and she had not heard the report of that echo. That echo was done at the hospital, whose computer system does not communicate with the pulmonologist.

    We later found out the patient had significant congestive heart failure, and we immediately admitted the patient, where she was stabilized. But I'd just point out that, indeed, the patient's clinical data was not readily transferred from the hospital to the clinician.

    So, in summary, I'd like to point out that, when physicians have access to data under the same computer system, that it's much more readily transferred to the clinician and, preferably, the patient gets results quicker.

    MR. ROATE: Two minutes.
DR. FOJTIK: Thank you for your time.

CHAIRWOMAN OLSON: Thank you, Doctor.

Next.

Please go ahead.

DR. SHEN: Good morning. My name is Dr. Emily Shen. I'm in here to support Mercy Crystal Lake Hospital.

I'm a family practice clinician with my clinic being in Crystal Lake. I have been with Mercy for over eight years serving the Crystal Lake community. I work with patients of all ages from newborn to the elderly, and a large percentage of my patients are either Medicaid or Medicare insurance. Many of these patients find it difficult to travel from one facility to the other.

Having access to service such as labs, X-rays, and other physician specialties in the same building greatly improves the access to care and, of course, quality of care. I know our proposed hospital and clinic would help other Mercy physicians, as well.

Patients should be granted access to the closer ER and hospital. This can further offer immediate emergency care to my patients instead of
making them travel a long distance to receive such
important care.

I'll give you an example. I currently have
a patient with a below-knee amputation, and he is
the caregiver of his wife, who is wheelchair-bound
and has a serious medical condition.

Having to travel from one place to the other, not only he has trouble with
taking care of himself, but taking care of his wife
is becoming increasingly difficult.

A hospital integrated with my practice with
the same electronic medical records improves my
ability to care for my patients during their
inpatient stay as well as the timely review of
records after discharge.

Too often I don't have immediate access to
the patient's medical records from other
hospitalizations from outside hospitals. These
definitely lead to delay of the treatment and
increase the chances of errors.

It has been my honor to serve the community
over the last eight years. I have seen a growing
community in Crystal Lake. I know a new clinic and
hospital is needed in this area to serve not only my
patients --

MR. ROATE: Two minutes.

DR. SHEN: -- but the growing community.

CHAIRWOMAN OLSON: Please conclude.

DR. SHEN: Please approve the Mercy Health Care.

CHAIRWOMAN OLSON: Thank you.

Next.

DR. HENNING: Hi. My name is Douglas Henning. I'm a board-certified pediatrician at Mercy Health Crystal Lake East. I've been practicing in the Crystal Lake area for 20 years. I'm here to support Mercy Health's small Crystal Lake hospital and clinic applications. As a primary care physician, I know how important it is to have coordinated care for my patients. Mercy Health's small hospital and clinic proposals provide community care, access to emergency care, continuity of care, and reduced costs. This is what our patients want.

For example, I order any testing for my current patients, they need to travel to other locations throughout the county to have this completed, sometimes multiple locations, depending
on the type of testing I've ordered, whether it be
for lab tests, X-rays, or to see a specialist. For
a parent with small children, this is often very
inconvenient, leading to difficulties in getting
care.

I recently saw a 14-year-old boy for a very
large lymph node that had not changed after
antibiotics. I referred him to my ear, nose, and
throat colleague in my own office.

As the node was very large and close to a
nerve, my colleague wanted an ultrasound prior to
doing the needed bypass. The ultrasound had to be
scheduled to be done at Mercy Health's main clinic
in Woodstock, a 20-minute drive away under the best
of traffic conditions. 3 miles but 20 minutes.

My point here is, if you're located in a
multispecialty clinic and small hospital, the entire
process could have been done the same day that would
include, if necessary, an outpatient surgical
procedure.

This would have saved this young man and his
parents days of worry as to whether or not he has an
overactive node versus lymphoma. This family would
have also, of course, saved money by decreasing
travel costs, time away from work to take care of his specialty follow-up visits.

In summary, I strongly believe both the clinic and hospital projects are critical in order for us to better serve Crystal Lake now and well into the future. I believe our small hospital and clinic projects will provide our patients enhanced care and convenience, increased efficiencies, and the potential to expand for additional access. Not approving the hospital and clinic application denies a hospital --

MR. ROATE: Two minutes.

DR. HENNING: If you want to truly serve the community --

CHAIRWOMAN OLSON: Please conclude.

DR. HENNING: -- I strongly urge you to approve this project.

Thank you.

CHAIRWOMAN OLSON: Thank you.

Next.

MR. JENSEN: Can you hear me? Okay.

Hi. My name is Tom Jensen. I'm from Mercy Health. That's J-e-n-s-e-n.

McHenry County has a public transportation
problem which acts as a major barrier to county residents receiving health care. In a 2017 Healthy Community Study, lack of public transportation was identified as one of the three major barriers to receiving health care in the county.

Mercy Health's Crystal Lake Hospital and ER would provide community residents who lack access to transportation to increased access in health care services. The greatest population density is in Crystal Lake and the surrounding communities. Right now there is no hospital and no emergency department in Crystal Lake.

In the Healthy Community Study, over 40 percent of those responding rated the public transportation system in McHenry County as poor.

Here are some comments: "McHenry County is sorely lacking in public transportation." "Public transportation in McHenry County is nonexistent."

In the study that Dr. Aurand spoke of, there were many comments from residents which highlight the problems. A 63-year-old female responded "The current emergency departments are on extreme opposite ends of Crystal Lake and require taking heavily traveled corridors."
A 37-year-old female responded, "Considering the size of our community, an all-encompassing ER, not immediate care, seems necessary. Route 14 is far too congested on reliable travel times, and it hinders the travel between Crystal Lake and Barrington."

There is a public transportation system in McHenry called MCRide, which is part of the poorly rated system mentioned above. However, MCRide does not operate on Sundays, MCRide does not operate on evenings after 7:00 p.m., and there is a cost, plus residents must book, at minimum, two hours in advance with no guarantee of accommodation.

Right here, this ninja turkey slicing dad needed ER care at 7:30 a.m. -- at or 7:30 p.m. -- on Thanksgiving --

MR. ROATE: Two minutes.

MR. JENSEN: -- and we all know how injuries and illnesses seem to be a part of Murphy's Law during evenings and weekends.

CHAIRWOMAN OLSON: Please conclude, Ninja Carving Dad.

MR. JENSEN: Yes.

(Laughter.)
CHAIRWOMAN OLSON: Do you still have your fingers?

MR. JENSEN: I still do. I'm in good shape.

Thank you very much.

CHAIRWOMAN OLSON: Thank you.

MR. MORADO: Okay. Next up we have Ben Slack, Bette Schoenholtz, Kelly Howard, Casey Haefs, and Dr. Jay MacNeal.

That's Dr. Jay MacNeal, Casey Haefs, Kelly Howard, Bette Schoenholtz, and Ben Slack.

CHAIRWOMAN OLSON: Please, somebody can go ahead.

MS. SCHOENHOLTZ: My name is Bette Schoenholtz.

CHAIRWOMAN OLSON: Pull the microphone way close.

MS. SCHOENHOLTZ: My name is Bette Schoenholtz, S-c-h-o-e-n-h-o-l-t-z. I am the director of Senior Services Associates, and I support the Mercy Health certificate of need proposals to build a hospital and multispecialty clinic in Crystal Lake.

Senior Services is an organization that serves older adults and persons with disabilities.
Last year we served over 11,000 needy and frail seniors in the county. Our staff performs prescreens for the Choices for Care program in all hospitals in McHenry County, and we provide a volunteer transportation program.

We see on a daily basis how our Crystal Lake area clients struggle with getting appropriate health care, due in large part to the lack of reliable transportation. These older adults are unable to access transportation for several reasons. Some can no longer drive safely. Others can no longer afford to maintain a car and pay for insurance. Sometimes the person is temporarily unable to drive due to surgery or illness.

Whatever the reason, losing the ability to drive becomes a barrier to receiving vital health care services that they need. And when you throw distance into the equation, getting appropriate service becomes even more difficult.

So as our clients age, they require ever-increasing levels of care. They are frequent visitors to the emergency room, and for years they have expressed a desire for an ED option that is closer to home.
Having an emergency room and multispecialty clinic closer to where they live would be a blessing. It would also improve coordination of care, which would not only benefit the clients who currently see doctors in the multiple Mercy Health locations.

First, patients would have the benefits of a multispecialty clinic with diagnostic capabilities and access to --

MR. ROATE: Two minutes.

MS. SCHOENHOLTZ: On behalf of Senior Services, I fully support this project, and I urge you to approve --

CHAIRWOMAN OLSON: Thank you.

MS. SCHOENHOLTZ: -- Mercy Health Care's application.

CHAIRWOMAN OLSON: Thank you.

Next.

Please, someone, go.

MS. HAEFS: Hi. My name is Casey Haefs. I have been a resident of Cary, Illinois, for three years. Prior to that, I lived in Crystal Lake for 10 years. I still spend most of my time in Crystal Lake since I have a 12-year-old son who's
very active in multiple sports.

I'm here today to show my support for both Mercy Health projects. I know, firsthand, Mercy Health's projects would be a great benefit to both me and my son. As a mother working full-time and raising a teenager, it becomes challenging to even make appointments with our hectic schedules.

There are no options for emergency services where I live. With my son playing several contact sports in Crystal Lake, that really concerns me. Not everything can be seen in an immediate care. Sure, I might use those services for a sore threat, but what about when my son breaks his ankle in a football game, suffers a head injury in a lacrosse game, or wakes up in the middle of the night with severe abdominal pain from appendicitis? I need to get him to an emergency room fast.

I believe we should have another option for health care. Just recently I, personally, had to visit Advocate Good Shepherd for severe stomach issues. Not only did they not have my medical records, but also, when I made my follow-up visit with my primary care physician at Mercy Health, it made it very difficult.
She didn't have my information; she didn't know what testing was done. I was the one telling here what they did at the hospital. Mercy Hospital and clinic projects will keep my care all under one medical record, making it easy for my doctors to keep track of my care.

For the sake of my health, as well as my family's, I urge you to approve Mercy Health's hospital and medical center.

Thank you.

CHAIRWOMAN OLSON: Thank you.

MS. HOWARD: Hello. My name is Kelly Howard, K-e-l-l-y H-o-w-a-r-d. I've been a member of the Crystal Lake community for 16 years. I'm very excited about Mercy Health's proposal to build a hospital and medical center in Crystal Lake.

Earlier this year my son called me in an emergency. He told me he hurt his ankle, it was extremely swollen and bruised. He was in a lot of pain, and I knew he needed medical attention right away.

Instantly I felt panicked; he isn't with me; I can't get him anywhere. If we had an emergency department in Crystal Lake, I would have sent him
there and he would have received medical attention within minutes. When this injury happened, the nearest emergency room was a 20-minute drive to Woodstock or nearly 30 minutes to Elgin.

Also last year, my daughter sustained an injury requiring surgery. Her surgeon operates in Harvard. If there was a hospital in Crystal Lake, I would have not had to drive the 80-minute roundtrip for her to have her surgery.

As expected, she was very groggy after receiving anesthesia. The long car ride home caused some motion sickness that we had to contend with. Additionally, the farther distance home delayed her elevating her foot, which she was ordered to do by her surgeon.

For me, having local access would bring peace of mind, knowing I can quickly see providers in an emergent situation. Having local emergency services is a must.

Please approve Mercy Health's hospital and clinic in Crystal Lake.

Thank you.

CHAIRWOMAN OLSON: Thank you.

MR. SLACK: Good afternoon. My name is
Ben Slack, B-e-n. Last name is Slack, S, as in "Sam," -l-a-c-k. I'm the executive director for the Epilepsy Foundation of North/Central Illinois, Iowa & Nebraska.

We provide epilepsy services for individuals with epilepsy in McHenry County, and we operate an office in Crystal Lake. I want to speak specifically today in support of the Mercy Health proposed projects.

Some of the biggest struggles that we face in the epilepsy community is -- one is lack of transportation. Most of our clients can't drive, and public transportation in McHenry County is extremely poor, so travel is always a difficulty for individuals with epilepsy.

And, secondly, the -- one of the major problems that we're facing right now is a lack of epilepsy subspecialists. There is no epilepsy subspecialist in McHenry County, and there is no epilepsy center in McHenry County, meaning that our individuals have to travel.

A third problem that we're seeing a lot of in McHenry County is that there is no overlapping coverage between Medicaid providers, meaning that
individuals either have to choose between their emergency room coverage or their specialist coverage, so individuals -- like the epilepsy centers in Chicago don't take the same Medicaid providers as the emergency room departments in McHenry County, so that means the individuals are having to choose between those two levels of coverage.

So for that, I'm hopeful that more options in McHenry County will be very beneficial to the individuals with epilepsy in McHenry County.

So thank you.

CHAIRWOMAN OLSON: Thank you.

DR. MAC NEAL: My name is Dr. Jay MacNeal. I'm the EMS medical director for Mercy Health. I'm responsible for EMS services in the 15-county service area. I'm board certified in both emergency medicine and the subspecialty of EMS. I have over 27 years of experience in the emergency medical field and am very familiar with EMS providers from first responders through critical care paramedics. I develop treatment and transport protocols as well as direct on-scene medical direction in the worst of situations.
I understand the opposition is touting confusion among residents and EMS regarding the level of care that we plan to offer at our proposed emergency department. I'm here to tell you there should be no confusion and, in fact, our competitors are the ones causing this confusion.

Cities both large and small across the country have emergency departments that offer various levels of care based on the needs and size of the community they serve, and there's no confusion as to where or what level of care they provide or where to go in an emergency.

We are proposing a comprehensive emergency department for the Crystal Lake community, which will provide adequate care for the vast majority of ED cases.

Immediate access is vital for those patients who are suffering a stroke or heart attack. Unfortunately, despite aggressive public campaigns nationwide, 33 percent of stroke patients and 50 percent of heart attack patients do not call an ambulance. Seconds count and providing immediate access to an emergency department for citizens in a city the size of Crystal Lake will save lives.
Quick interventions to stabilize the patient and, if needed, transfer the patient to another hospital will provide better outcomes.

For the patients that call 911, paramedics and other prehospital professionals are proficiently trained to triage patients on the scene. There are extensive protocols in place for EMS professionals to follow, ensuring that patients are transported to the nearest appropriate hospital.

I also find it ironic that the opposition feels there will be confusion, as these protocols currently guiding EMS in McHenry County are guided by their EMS medical direction in accordance with IDPH regulations and regional policies. Our competitors should know firsthand that their EMS professionals will not be confused about where to take critically ill patients.

Every day patients who come to our small hospitals with these types of conditions receive expedient care by our emergency medicine-trained physicians and staff.

MR. ROATE: Two minutes.

DR. MAC NEAL: Critical, time-sensitive intervention that leads to lives being saved --
CHAIRWOMAN OLSON: Please conclude.

DR. MAC NEAL: I strongly urge you to consider supporting this.

Thank you.

CHAIRWOMAN OLSON: Thank you.

MR. CONSTANTINO: Madam Chair --

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

CHAIRWOMAN OLSON: It is one o'clock. I believe what we're going to do is break for a 45-minute lunch.

We do have 13 more for public participation, so we're going to break for -- we will reconvene at 1:45 promptly.

(A recess was taken from 12:59 p.m. to 1:52 p.m.)

CHAIRWOMAN OLSON: We'll continue with public participation.

The next five.

MS. AVERY: Okay. The next five we have are Dr. Glenn Milos, Theresa Hollinger, Hayden Creque, and Paul Van Den Heuvel -- Van Den Heuvel -- and Dave Syverson -- Senator Syverson. I'm sorry.

CHAIRWOMAN OLSON: Once again, two-minute time limit, and please state your name for the court
Please go ahead.

DR. MILOS: Good afternoon. My name is Dr. Glenn Milos, and I'm the regional medical director of emergency services for the emergency departments at Mercy Health.

I oversee all aspects of emergency care for our hospitals in Janesville, Wisconsin; Lake Geneva, Wisconsin; and Harvard, Illinois. I am an emergency medicine physician, and we save lives on a daily basis. I'm here to talk to you today about why the residents of Crystal Lake need and deserve a hospital with a dedicated emergency department.

It was not long ago when emergency departments were staffed with any kind of physician available to work. They were staffed with surgeons, primary care physicians, and psychiatrists. But what does a psychiatrist know about treating your heart attack or stroke?

Since that time emergency medicine has evolved as a specialty that provides a wide range of conditions that require special skills delivered in a very time-sensitive manner. Today, emergency departments are staffed with board-certified, highly
skilled specialists who can handle any emergency problem you might have.

The challenge now, however, is how long will it take you to get to the emergency department to start receiving care. Will you get there in time?

When you are having a heart attack, every minute spent getting to the hospital is another minute that your heart is deprived of oxygen. For each minute you spend getting there when you are having a stroke, approximately 1.9 million neurons die per minute.

If you asked me how many minutes I'd be willing to spare in an emergency, I'd say, "Well, none." And I imagine you would say the same. In medicine we like to say "Time is muscle. Time is brain. Time is life."

The residents of Crystal Lake deserve to have the highest quality emergency care, and they deserve to have it available right within their community. Mercy Health wants and needs to bring this care to the Crystal Lake community.

I assure you that your favorable vote today will result in many lives being saved tomorrow and will enable the residents of Crystal Lake to receive
timely, evidence-based, compassionate medical care --

MR. ROATE: Two minutes.

DR. MILOS: -- close to home.

CHAIRWOMAN OLSON: Please conclude.

DR. MILOS: I have a passion for making lives better. This is who I am, and this is who we are at Mercy Health.

CHAIRWOMAN OLSON: Thank you.

DR. MILOS: Thank you.

CHAIRWOMAN OLSON: Next.

MS. HOLLINGER: I'm Theresa Hollinger, director of nursing at Mercy Health Hospital and Medical Center in Harvard.

I have been a nurse for over 24 years, and I've worked in a wide variety of environments, from very small critical-access hospitals to large Level I trauma centers. Each type of hospital has its advantages for patients.

Working in a small hospital provides a great opportunity to really get to know my patients in a more meaningful and personal way. We have a unique method of providing care based on hospital operational efficiencies.
At a small hospital many of our supervisory, ICU, and medical nurses are cross-trained in multiple environments to facilitate agility when patient needs are higher in one area over another. This flexibility, including leadership, fosters teamwork and collaboration regardless of primary unit. The high level of competence and familiarity in various work environments enables us to provide specialized, patient-specific care anywhere it's needed.

Because we are a large, Illinois, vertically integrated medical system, we provide the same high level of services to every Mercy Health patient regardless of the size or the location of the facility.

At Harvard the majority of our nursing partners are bachelors prepared with a very high percentage of our nursing partners as master-prepared nurses, all practicing at the bedside.

It's important to think about the needs of the community we're seeking to reach. A community of over 50,000 souls, Crystal Lake has the right to accessible emergency care. Without an emergency department, Crystal Lake is in a position of risk as
patients have to navigate traffic in a state of panic seeking treatment.

To illustrate this need, I have recently heard from one of the 9500 residents of Harvard, who felt that, if Harvard's ER was not there, her son would not have survived to reach a farther facility. The individual had begun to have an allergic reaction at home and decided to drive the few minutes from his home. By the time he arrived, his throat was closing and he could not speak to explain what was happening. His airway had quickly become blocked and he was having great difficulty breathing.

The clinical expertise of our nurse and --

MR. ROATE: Two minutes.

MS. HOLLINGER: -- quick assessment by one of our board-certified --

CHAIRWOMAN OLSON: Please conclude.

MS. HOLLINGER: -- emergency department physicians resulted in the patient being immediately treated.

CHAIRWOMAN OLSON: Thank you.

MS. HOLLINGER: Please support.

CHAIRWOMAN OLSON: Thank you.
MR. CREQUE: Good afternoon. My name is Hayden, H-a-y-d-e-n, Creque, C-r-e-q-u-e. I serve as assistant general counsel for Mercy Health. And, Ms. Avery, I will always answer to "Mr. Crackoo" [phonetic].

(Laughter.)

MR. CREQUE: I'm a bit new to this process, and I've got to be honest with you. I'm a bit surprised at the amount of resources expended opposing a 13-bed hospital. Our opponents clearly want to do one thing and one thing only, eliminate competition.

They want to continue to have applied an outdated health care model that does not reflect the reality of a new health care economy, which is deemphasizing hospitalization and focusing on delivering the right care at the right time in the right setting.

To be clear, hospital beds are still needed. They're just not needed in increments of a hundred. Indeed, arguably, the opponents have conceded this point in recent Crain's articles. Advocate has said
its existing cost structure is not sustainable. As a result, they have begun a course correction.

In advance of its merger with Northwestern, Centegra's troubles have also been well publicized. Crain's reported that it's likely as a result of constructing hospitals ill-suited to today's health care environment.

Advocate has 431 licensed beds, Centegra 413 in the McHenry County area. They're exaggerating the impact of our proposal. At the end of the day, we're talking about a census that's less than 2 percent in terms of impact.

Mercy Health understands and we're deeply committed to size and locate facilities to successfully deliver necessary services close to where parents live -- sorry; that would be "patients" -- but parents, too.

We also understand the financial, geographical, and social hurdles traditionally underserved patient population have to traverse. Our application to serve the Crystal Lake area reflects that understanding. We have 5,501 signed petitions in support.

We ask that you give thoughtful
consideration --

MR. ROATE: Two minutes.

MR. CREQUE: Well, thank you. Two minutes.

Thank you.

(Laughter.)

CHAIRWOMAN OLSON: Thank you.

MR. VAN DEN HEUVEL: Hello. I am Paul Van Den Heuvel, Mercy Health's vice president and general counsel. My last name is spelled V-a-n capital D-e-n capital H-e-u-v-e-l, and, apparently, only difficult last names can work at Mercy.

(Laughter.)

MR. VAN DEN HEUVEL: I ask that you please consider the following as you deliberate today: Advocate, with 3,500 total licensed beds, and Centegra, with a 413-bed super monopoly, want you to believe that Mercy Health's 13-bed hospital is a threat to their empires and the entire Illinois regulatory structure. That is simply absurd.

Let's review the reality: Mercy Health's innovative yet modest proposal follows the form of our innovative Rockford hospital applications which this Board unanimously approved in November of 2015.

Specifically, our hospital application
respects State standards, meeting all key
requirements, including cost. It's odd to hear cost
cited as an issue, given the State's report clearly
conveys that Mercy Health meets cost standards. We
will present more on this issue during the hearing,
but just months ago you rightly approved a
$35 million surgical center and a $46 million health
and fitness center.

Two, for those few standards that we do not
meet, there is strong rationale for not doing so.
For instance, as to the 100-bed standard, we have
proposed a proper-sized facility to deliver
necessary services to the Crystal Lake area.

Third, our application simply seeks to
redistribute 13 of Mercy Health's existing licensed
beds within the same planning area. It will not
result in any increase in the bed inventory while
maintaining our commitment to Harvard.

We seek to apply a more patient-centered use
of these beds to the Crystal Lake area population.
This includes comprehensive emergency services,
which 65 percent of the area's residents and other
public officials have expressed are needed.

I urge you to reject the protectionist
tactics of our competition and approve Mercy Health's modest yet innovative 13-bed hospital application.

MR. ROATE: Two minutes.

MR. VAN DEN HEUVEL: Thank you.

CHAIRWOMAN OLSON: Thank you.

SENATOR SYVERSON: Thank you. My name is Senator Dave Syverson. I'm also a member on the board of Mercy Health, and I'm here in support of these two projects.

The projects that are before you today are both innovative and are consistent with the goals of the Health Facilities Planning Act. It's because of that I believe they should be approved.

Now, it's not surprising that competitors are here to oppose this project. I can understand that. They don't want competition in their markets, but that's not good for consumers. I'm still trying to wrap my head around why two of the largest, wealthiest health systems in the state are concerned about a 13-bed hospital, especially going into a community where they have not wanted to be in the past.

These two systems generate billions of
dollars of revenue annually. This little
13-bed facility, which is not a microhospital,
wouldn't even be a rounding error on their balance
sheet.

However, the impact this will have on the
families that live in Crystal Lake and do not have
these services, that find getting transportation to
another community -- as stated, 20 minutes away --
to be difficult, to them this project will be a
world of difference. This is why you have local
leaders from senior citizen programs, health
departments, epilepsy association, and others here
supporting this project.

This request is consistent with the purpose
of the CON act, in that it addresses the unmet needs
of the families of Crystal Lake, a community, by the
way, that has more Medicaid residents than Harvard.

On a side note, Mercy -- while others talked
about serving Medicaid, Mercy, I believe, is the
largest Medicaid provider outside of Chicago. This
innovative solution solves the problem for the
people in Crystal Lake without adding one new bed in
the county. It's just shifting beds to where
they're needed most, to a community where nearly
50,000 people live without --

MR. ROATE: Two minutes.

SENATOR SYVERSON: -- important local health care services that we're all used to.

CHAIRWOMAN OLSON: Please conclude.

SENATOR SYVERSON: Thank you for your time.

CHAIRWOMAN OLSON: Thank you.

Next.

MR. MORADO: First off, we have Tracey Klein, Dirk Enger, John Hanley, and Matthew Watson.

Again, that's Tracey Klein, Dirk Enger, John Hanley, and Matthew Watson.

UNIDENTIFIED FEMALE: John Hanley already went.

UNIDENTIFIED MALE: Matthew Watson already spoke, as well.

UNIDENTIFIED FEMALE: There are others.

MS. KLEIN: Good afternoon. I'm Tracy Klein, like Calvin but no relation. And I'm -- I represent Mercy Health.

As lawyers, we have an ethical duty of honesty toward the tribunal. I was a bit disheartened to see and hear some of the commentary by attorneys for the opposition today. I have been
trying to kind of keep track of all the misstatements, and there have been several.

First, our opponents' attorneys focus on the per-bed cost of the project as if it's a legal standard that the Board is required to adhere to. No such review criterion is found in the Planning Board's governing regulations. The only review criterion relating to cost in the regulations is the cost per square foot, 1120-Appendix A, and Mercy happens to meet that standard.

Second, the opponents' attorneys reference the hundred-bed minimum standard as if it's a precondition for Board approval. As you all know, the 100-bed minimum medical/surgical unit standard itself is not an absolute requirement. Rather, it's one of many standards that the Board may consider in reviewing an application.

Obviously, your legal standard is substantial compliance but with the balance of all facts and circumstances in the criteria in the reg and, also, the purposes of the Act.

Third, there was the unsupported statement made by Attorney Shepley that this project is not permitted under the Planning Act, period. I don't
know why we'd be here.

Fourth, we heard that this sets up a new precedent and that it requires new standards by this Board. It's an innovative project. No question about it. But to suggest, as care migrates to the outpatient setting, that your regulations don't allow you to consider a broad range of projects is, frankly, not correct. You can see it in your own work, including the fitness center for 46 million in prior meetings.

MR. ROATE: Two minutes.

MS. KLEIN: Fifth, this is not an alternative --

CHAIRWOMAN OLSON: Please conclude.

MS. KLEIN: -- model.

In closing --

CHAIRWOMAN OLSON: I need you to conclude.

MS. KLEIN: I urge your support.

CHAIRWOMAN OLSON: Thank you.

MR. ENGER: Thank you, Board members. My name is Dirk Enger. First name is spelled D-i-r-k; last name, E-n-g-e-r. I am president of Ironworkers, Local 393, in Aurora, Illinois. Our local covers five counties in northern Illinois, all
I'm here today not on behalf of jobs for you. I am here on behalf of my members, numerous members, which live within that area in which this project would be built if you granted it. What it gives is my members access to good quality, affordable health care. I have many members ranging from many ages that would benefit from this project.

Also, to let you know that our local has built, with the people that are here in opposition, every single facility that has been mentioned on record here today. They all started out small; they all grew. How they grew and how they manage their money is their own perspective.

But I also would just like to add in that I also am a former County Board member for DuPage County, which DuPage County, as you know, is the second largest in the state. We also are the only one -- one of the two counties that has a nursing home. I am very proud to have sat as vice chairman on the human services committee and developed it.

So today I ask you to take -- judge your judgment based upon the stats. And what I've heard here today I'd just like to close with. It's about
quality of life, that you have to give your
responsibility to the residents of Illinois and
especially McHenry County. I hope you base it upon
that but also realize this is not, as it's known in
the development committee -- which I sat on, also --
a NIMBY project, "not my backyard." And that's what
I am very disappointed in, seeing the other people
that have given testimony here today based upon the
dollar.

Health care should never be based upon the
dollar. That's why our country's in trouble like it
is now. People can't afford health care. We should
be providing health care to those that need it.
Many here took an oath. I took an oath to represent
my members, and that's why I'm here today, asking
you to strongly support this project.

Thank you.

CHAIRWOMAN OLSON: Thank you.

MR. MORADO: We do have four more, Madam
Chair, Pam Cumpata, Ronald Eck, Mary Maule, and
Charles Wheeler.

MS. CUMPATA: Okay.

Hello. My name is Pam Cumpata, and I serve
as the president of the McHenry County Economic
Development Corporation.
Our mission is to promote and enhance the economic health of McHenry County through the retention, expansion, and attraction of commerce and industry. We do all this to be a con- -- to have an opportunity -- or optimal quality of life for our citizens.

On May 9th the McHenry County Economic Development Corporation board of directors approved a resolution to support the economic impact generated by the Mercy Crystal Lake microhospital and medical office, which has been sent to the Illinois Health Facilities and Services Review Board.

This project will generate jobs, income, and capital investment for the region, which aligns directly with our corporate mission. In addition to the jobs, income, and capital investment, the economic activity associated with this project will also facilitate infrastructure improvements at the area of Route 23 and Three Oaks Road in Crystal Lake.

McHenry County Board Chairman Jack Franks was unable to attend today, but he has authorized me
to convey that he is personally supporting this
project, "creating" -- to quote him -- "creating
hundreds of jobs, both during construction and in
the long term, plus all of the economic spin-off and
growth that will occur to support this new project
and population is good for our region. It will
attract business and place Crystal Lake on par with
other cities of similar size, almost all of which
have a local hospital."

Thank you.

CHAIRWOMAN OLSON: Thank you.

MR. ECK: My name is Ron Eck. It's R-o-n
E-c-k. I'm the business representative for
Carpenters, Local 2087.

The McHenry County Building Trades
Association were planning to have many speakers here
today; however, out of respect for the Board's time,
I'll speak to you on behalf of all of our trades.

We'd like to express our full and unwavering
support of Mercy Health's proposed projects. These
projects are good for our local economy. Local
contractors and businesses will have an opportunity
to participate in the construction process, and the
project will also provide long-term jobs to area
residents when the construction is completed, all of
which will feed into Crystal Lake's positive
economic momentum.

When Mercy completes this project,
Crystal Lake will be far more attractive to new
businesses, enhancing workforce attraction and
retention.

We need this type of continued growth if
we're going to be an economical viable city. We
need to think about the future and continue to push
forward, supporting innovative projects and
embracing change. It's the only way to remain
viable in our area.

On behalf of the McHenry County building
trades, we fully support Mercy's applications to
construct the proposed hospital and medical center
in Crystal Lake, and I also encourage this Board to
approve this project.

I thank you for your time and consideration.

Ron Eck, Carpenters, Local 2087.

Thank you.

CHAIRWOMAN OLSON: Thank you.

MR. WHEELER: Thank you, members of the
committee. I appreciate the opportunity of
addressing you today on this precedential issue of us building a hospital here in --

MS. AVERY: Sir, you've going to have to move it closer so the court reporter can hear you.

MR. WHEELER: Thanks for telling me.

I appreciate it.

My name is Chuck wheeler, and I'm a County Board member as well as chairman of the community health and public services committee. I have a background in health care and health care economics.

McHenry County needs this project. Centegra currently has a monopoly in McHenry County, in that it owns and operates 95 percent of the licensed beds, totaling 413 hospital beds.

Mercy Health's Crystal Lake small facility will provide patient choice. Centegra's motivation in opposing these projects is clear: They want to eliminate competition.

In recent years residents of McHenry have begun seeking care outside of McHenry County, and I and our family are one of those that do that. According to the IDHP [sic] and the IHFSRB statistics, McHenry County hospitals had a collective 45,503 medical/surgical patient days in
2013. Compare this to the 52,154 medical/surgical patient days recorded for McHenry County residents outside of the county. More McHenry County residents received care outside McHenry County, far from home, than within the county.

We believe the reason for this exodus is multifaceted and it includes patient perceptions of quality --

MR. ROATE: Two minutes.

MR. WHEELER: -- cost, and a lack of accessible facilities.

CHAIRWOMAN OLSON: Please conclude.

MR. WHEELER: Thank you very much for allowing me to address you.

CHAIRWOMAN OLSON: Thank you.

MS. MAULE: My name is Mary Margaret Maule. M-a-r-y M-a-r-g-a-r-e-t; it's one word. Last name, M-a-u-l-e.

I'm the president of the Crystal Lake Chamber of Commerce, and I'm here today to express the chamber's support for the Mercy Health's certificate of need request to build a multispecialty medical center and hospital in Crystal Lake. Mercy Health is an active member of
my chamber and an ongoing contributor.

Our mission at the chamber of commerce is to create value and opportunity for our members with the belief that a positive business climate is an integral part of a strong and healthy community. The Mercy Health projects will bolster the economy. The project will create permanent, high-paying jobs with Mercy Health in the Crystal Lake facility.

The economic boost that this project offers makes our region far more attractive to new business and business retention. We must continue to innovate and support positive development to grow our community.

For these reasons, the chamber of commerce board of directors would like to offer its support for the Mercy Health certificate of need proposals to build a hospital and clinic in Crystal Lake. We believe in this project. It will create jobs; it will bring commerce to our area and to your members. It's a significant spillover economic effect that will lift us all and improves access to critical health care services.

We strongly urge you to support and approve these proposals for the benefit of Mercy Health.
Thank you.

CHAIRWOMAN OLSON: Thank you.

That concludes the public participation portion?

MR. MORADO: Yes.

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CHAIRWOMAN OLSON: Next, we have items approved by the Chairwoman.

George.

MR. ROATE: Thank you, Madam Chair.

The following items were approved by Chairwoman Olson in absence of the full Board:

E-018-17, Fresenius Medical Care, Lake Bluff, change of ownership; E-019-17, SwedishAmerican Hospital, Rockford, to establish a 10-bed NICU, neonatal intensive care unit; E-021-17, St. Anthony Health Center, Alton, to discontinue pediatrics service; E-022-17, OSF St. Clare Hospital, Alton, to discontinue inpatient physical rehab and long-term care services; E-023-17, DMG Center for Pain Management, Naperville, change of ownership; E-024-17, DMG Surgical Center, Lombard, change of ownership; Permit Renewal 16-020, Dialysis Care Center of Oak Lawn, an eight-month permit renewal; Permit Renewal 16-022, Dialysis Care Center, Olympia Fields, an eight-month permit renewal.

Thank you, Madam Chair.

CHAIRWOMAN OLSON: Thank you, George.

- - -
CHAIRWOMAN OLSON: Next, we have items for State Board action. First, we have permit renewal requests, Project 15-005, Presence Lakeshore Gastroenterology, Des Plaines, for a six-month renewal.

May I have a motion to approve this permit renewal.

MEMBER BURZYNSKI: So moved.

MEMBER JOHNSON: Second.

CHAIRWOMAN OLSON: Second.

Mr. Constantino, your report.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The Applicants are proposing a six-month permit renewal for Project No. 15-005, which was the establishment of a limited specialty ASTC in Des Plaines, Illinois.

This is the second permit renewal request for this project. The project cost is a fraction of $3.1 million.

Thank you, Madam Chairwoman.

CHAIRWOMAN OLSON: And there was no --

MR. CONSTANTINO: No findings, no opposition.

CHAIRWOMAN OLSON: Okay.

Do you have comments -- I'm sorry. We need
to swear you in first. Be sworn in.

THE COURT REPORTER: Would you raise your
right hands, please.

(Two witnesses sworn.)

THE COURT REPORTER: Thank you.

MR. STERN: Good morning -- good afternoon.
My name is Les Stern. I'm the chief operating
officer for Presence Medical Group. With me is our
certificate of need counsel Clare Ranalli.

We're here before you to request a permit
renewal. The surgery center is basically complete.
We've gone through the design and life safety code
survey with the Illinois Department of Public
Health. We are about to conduct our clinical
survey.

When the clinical survey is complete, we
anticipate beginning to see patients in August or
September, based on the timing of the survey. We
anticipate no issues with the opening of the center
and having our first patient at that time.

With that said, we thank you and will answer
any questions.

CHAIRWOMAN OLSON: Thank you.

Questions from Board members?
CHAIRWOMAN OLSON: Seeing none, I'd ask for a roll call vote.

MR. ROATE: Thank you, Madam Chair. Motion made by Senator Burzynski; seconded by Mr. Johnson.

Senator Burzynski.

MEMBER BURZYNSKI: Aye.

MR. ROATE: Senator Demuzio.

MEMBER DEMUZIO: Aye.

MR. ROATE: Mr. Johnson.

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

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on the State agency report.

MR. ROATE: Thank you.

Ms. Murphy.

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

MR. ROATE: Thank you.

Mr. Sewell.

VICE CHAIRMAN SEWELL: Yes. There were no
findings.

MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: Yes, for reasons stated.

MR. ROATE: Thank you.

There are 7 votes in the affirmative.

CHAIRWOMAN OLSON: The motion passes.

Thank you.

MR. STERN: Thank you.

- - -
CHAIRWOMAN OLSON: There are no extension requests, no exemption requests, no alteration requests, no declaratory rulings.
CHAIRWOMAN OLSON: Under Health Care Worker Self-Referral Act we do have business.

Juan, I'll let you take that one.

MR. MORADO: Yes. You'll notice in your packets we have a State Board staff report for a Health Care Worker Self-Referral Act opinion.

It's from a Ms. Modglin, who is a speech pathologist, and she's a practitioner of the healing arts. And she would like to have a determination made on her work being done for McLean County Unit District No. 5.

So what you're doing today is you're voting to deem this request complete, which will give Board staff the opportunity to write up her opinion and then present it to her. In order to deem a Health Care Worker Self-Referral Act request as complete, it needs seven affirmative votes.

So what you have before you is a breakdown of the request that was submitted and all the information that was submitted. Board staff believes that everything that's needed to be turned in has been turned in and so they -- today we're seeking an affirmation of seven votes.

CHAIRWOMAN OLSON: May I have a motion to
approve this request.

VICE CHAIRMAN SEWELL: So moved.

CHAIRWOMAN OLSON: And a second, please.

MEMBER BURZYNSKI: Second.

CHAIRWOMAN OLSON: I'll ask for a roll call vote, please, George.

MR. ROATE: Thank you, Madam Chair.

Motion made by Mr. Sewell; seconded by Senator Burzynski.

Senator Burzynski.

MEMBER BURZYNSKI: I vote yes based on the completeness of the request.

MR. ROATE: Thank you.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon --

THE COURT REPORTER: I'm sorry. I couldn't understand you.

MEMBER DEMUZIO: Yes, based upon the finding here.

THE COURT REPORTER: Thank you.

MR. ROATE: Thank you.

Mr. Johnson.

MEMBER JOHNSON: Yes, based on the report and comments from counsel.
MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on counsel's recommendation.

MR. ROATE: Thank you.

Ms. Murphy.

MEMBER MURPHY: Yes, for reasons stated.

MR. ROATE: Thank you.

Mr. Sewell.

VICE CHAIRMAN SEWELL: Yes, for reasons stated.

MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: Yes, reasons stated.

MR. ROATE: Thank you.

That's 7 votes in the affirmative.

CHAIRWOMAN OLSON: Motion passes.

We have nothing under status reports on conditional/contingent permits.

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CHAIRWOMAN OLSON: We will now move to applications subsequent to initial review.

I will call to the table Project H-01, 17-002, Mercy Health Hospital. Please come to the table.

While they're doing that, I would ask for a motion to approve Project 17-002, Mercy Health Hospital, to establish a 13-bed hospital in Crystal Lake.

MEMBER JOHNSON: So moved.

MEMBER DEMUZIO: Second.

CHAIRWOMAN OLSON: I have a motion and a second.

The Applicants will be sworn in, please.

THE COURT REPORTER: Would you raise your right hands, please.

(Eight witnesses sworn.)

THE COURT REPORTER: Thank you.

CHAIRWOMAN OLSON: Mr. Constantino, your report.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The Applicants are proposing the establishment of a 13-bed hospital in Crystal Lake,
Illinois, at a cost of approximately $79.5 million. The expected completion date is November 30th, 2020.

There was a public hearing held on this project, and the State Board staff has received a number of support and opposition letters regarding this project. There were State findings -- State Board and staff findings, as noted on page 5.

Thank you, Madam Chairwoman.

CHAIRWOMAN OLSON: Thank you, Mike.

And I'm sure you have comments for the Board.

MR. BEA: Thank you. Should I begin?

CHAIRWOMAN OLSON: You can, please.

MR. BEA: Thank you, Chairman -- Madam Chairman.

Good afternoon, Board members, staff, and representatives of the Department of Public Health.

I'm Javon Bae, CEO of Mercy Health, based in Rockford, Illinois, the Applicant in connection with our Crystal Lake hospital and clinic applications.

I'd like to introduce members of our -- who are up at the table -- of our project team.

We have Ralph Weber, who is a CON consultant with us. And we have Tracey Klein, who introduced
herself earlier with Reinhart; Jeni Hallatt, vice
president in the Crystal Lake area with Mercy
Health.

Dr. Jason Bredenkamp, the medical director
of our emergency services at Mercy Health; John
Cook, the health systems CFO; Paul Van Den Heuvel is
the general counsel; and Dr. John Dorsey, who is our
chief medical officer; and Matt Sanders, who is --
I guess Dr. Dorsey is not here -- or is he? I can't
see back there.

Dr. Dorsey is here. Okay.

CHAIRWOMAN OLSON: Do you want him to be
sworn in?

MR. BEA: Yeah. That would be good, I guess,
if you don't mind.

CHAIRWOMAN OLSON: Can we swear Dr. Dorsey
in, please?

THE COURT REPORTER: Would you raise your
right hand, please.

(One witness sworn.)

THE COURT REPORTER: Thank you.

CHAIRWOMAN OLSON: Thank you.

MR. BEA: Thank you.

I'd like to begin by just sharing the fact
that the Federal government, as you all know, is working on a new health plan nationwide. The one thing we've been able to ascertain so far is that they're definitely moving from a volume-based system to a value-based system.

And I think it was reported earlier by Mr. Ladd Udy, who is our director of population health, that we can look at the ACO reporting requirements to the Federal government for our ACO members, and so we can -- it's an apples-to-apples comparison with Advocate and Centegra, and I think Mr. Udy alluded to the fact that we are, as a system, approximately 20 percent lower in our costs and just under 10 percent higher in quality.

And, frankly, that comes from looking at health care differently. Instead of having this fragmented pluralistic system where patients have to go to this location to see a primary care physician and then be sent to a specialist who doesn't have the clinical information or the test results from the primary care and then go to an ambulatory care center or to a hospital who doesn't have the results and the tests are repeated -- that's what all contributes to the high cost of care, and that's
what contributes to the fact that there's clinical
gap in care.

And so, clearly, what the accountable care
organization is under the Affordable Care Act and
the way, actually, President Obama designed the
Affordable Care Act is to bring about an
integration, vertical integration of care where
health care providers will manage all types of
levels of care from the time the patient enters the
office until the time the patient may have to be
discharged from other -- some other alternative
setting, and that requires one medical record.

And, frankly, we have based our model -- and
we've done this for three decades -- on the
Mayo Clinic model in the sense that Mayo discovered
over a hundred years ago that, if you integrate the
inpatient and the outpatient care, the doctors and
hospitals are contiguous to each other, and there's
one medical record, that you're going to get this
better quality of care and at a lower cost. And so,
frankly, that's what Mercy's done to be able to
achieve the results over and over.

And, you know, our competitors or our
opponents have talked about we're trying to escape
Harvard. That's not the case at all. Harvard is a very successful small hospital for us, just like the small hospital that we have in Lake Geneva, Wisconsin.

Here, you have a hospital that had 18 beds, was ready to close, has 27 percent Medicaid, high indigent population in Harvard, less than 10,000 people. And we invested $26 million in it, put in new ORs, new emergency room; we did a six-bed new unit. And Harvard today is just, to me, a stellar organization because it generates a 5 1/2 percent return on a 27 percent Medicaid mix, which is about a million to $2 million a year in net income.

Now, our average census -- back when we tried to do a CON in 2003, 14 years ago, when we sought 70 beds, we were using those 18 beds. Today, our average daily census is 4 patients at Harvard, but inpatient care only represents 30 percent of our total revenue there. 70 percent is outpatient revenue.

We have a vascular surgeon there. We have orthopedic surgeons. All of our services are going to stay at Harvard. All of our doctors are going to
stay there, the emergency room, the surgery suites. They're all going to stay there. We just don't need to have 13 beds that are mothballed, that we don't use.

And so the whole vision is to be able to do what we did for Harvard, in a city of less than 10,000, for Crystal Lake. It's a city of 50,000, five times larger, because -- and primarily what I think, if you talk to the residents of Harvard, is being able to have that access to emergency care, so that's what I'd like to talk with you about today.

And the proposed hospital is going to allow us to be able to do this because, when you have an emergency room, you've got to have some short-stay beds to be able to stabilize a patient overnight. Any of you -- you certainly look healthy enough. If you came in for your gallbladder removed, you will probably be able to be sent home in four to six hours.

But if you bring your 89-year-old grandmother, with her metabolism that she has, it's fragile, she may need to be stabilized overnight. So the same simple outpatient procedure is different based upon the other physical attributes of the
patient. That's the reason why, when we have this emergency room, we're going to be able to treat 97 percent of all cases, which I'll allude to in a minute.

So the idea is just to be able to bring this very needed service to a city of 50,000 people that has really been needed for a long time and why there's been all of this community, agencies -- the director of the public health department. He was up here earlier saying that 65 percent of people leave McHenry County for health care. And I think he said the average for the other counties in the state is less than 10 percent, so it shows there's something wrong going on in McHenry County.

So our CON today, our request today, is really very similar to what we brought to you in November 2015, and you kindly and unanimously approved being able to take underutilized beds at Rockford Memorial Hospital, 194 beds out of the 400 beds, and move them to a location where they're needed, which is now going to allow us to be able to go back, by offloading those beds when the new facility's done, and do a total retrofit at a facility on the west side of Rockford that has been
stagnant with facilities that are 60 years old. And I just want to just give you a little footnote of how that's going since you approved that.

We were here before you and reported that Rockford Memorial had something close to -- it was $48.7 million in losses in the previous five years, an average of $10 million a loss. In our first year of operating it, we had a $22 million net income from operations. And so we can talk a lot about how that's all happened, but I think that's the difference of what management does.

And I want to make another footnote, too, since we had opponents up here talking about a $40 million lost of Centegra. Their $40 million loss is not due to the fact that they've built Huntley. The facility component of the health care dollar represents 7 percent. 7 percent. 93 percent has the ongoing operation.

But they reported to their bond brokers that they haven't been managing the revenue cycle, billing properly, collecting properly, so they've had tens of millions of dollars of write-off. That's called management.

And not doing this facility, not giving the
50,000 people of Crystal Lake who don't have an emergency room -- not giving that isn't going to solve Centegra's problem. That's easily solved another way.

So what we are proposing is to bring a small hospital to Crystal Lake -- and mainly an emergency room -- to try to address the over 7,500 patients we have that are on Medicaid and charity and have tremendous barriers to care.

There's a study done by the doctor from Purdue who said the biggest barrier in Crystal Lake to the Medicaid and the charity and the elderly to getting care is not getting care when they get to the place; it's the transportation. It's being able to get to one of the emergency rooms in these other cities. That's their biggest barrier to care, and that's why we've heard people from the community come up.

And so what we propose is to do a 13-bed hospital and taking our unutilized beds -- the difference between what our average daily census is in Harvard -- we're going to leave an extra bed there -- and move 13 beds to Crystal Lake, where there's five times the population, have two
operating rooms, just like we have in Harvard, two
procedure rooms, a comprehensive 24/7 emergency
room, comprehensive radiology and imaging, a full
pathology lab, in-house pharmacy services, and a
sleep study center.

In our long-standing patients in Crystal
Lake -- we have 30,000 patients in Crystal Lake now.
Our doctors have over 43,000 patient visits. We
have over 20 physicians, multispecialty physicians,
and we want to be able to consolidate those
20 physicians into one location. That's the
multispecialty clinic.

So that with the emergency room, even though
I have board-certified emergency trauma physicians
for the emergency room 24/7, if a patient needs a
cardiologist, an orthopedic surgeon, an ENT
specialist, they'll be on-site in the clinic or be
on call for the emergency room.

It's going to be a very successful hospital,
just like we've experienced in Harvard and Lake
Geneva, Wisconsin.

I want to connect one other dot, too. When
we built that hospital in Lake Geneva, Wisconsin, it
was in 2009, at the time that Centegra was doing
Huntley. And we built a 25-bed beautiful hospital in Lake Geneva for $43 million.

And yet -- you wouldn't know this. In 2009 where were we at? The crash. The material costs, the construction cost was a fraction of what it is today. That's why we built a 25-bed, unbelievable hospital -- you should see it sometime -- in Lake -- between Lake Geneva and Delavan -- for 43 million.

And yet the fitness center at Kishwaukee is going to cost 46 million today that was just recently approved. It's just the difference in the construction costs and material costs.

But I go back to the fact the cost of the facility is the issue. That's only 7 percent of the patient care dollar, for the depreciation and interest over time. It's the -- how you operate it. It's eliminating the duplication of testing. It's being able to streamline and manage the patients' care. That's where the real cost comes in and the cost savings or the cost-effectiveness.

Again, Mercy has been, for a long time, a pioneer in vertically integrated and integrated health care. We've had -- and we've been, actually, an accountable care organization for decades. We've
got over 600 W-2 physicians, five hospitals, and
80 multispecialty medical centers in 50 communities.

Our corporate -- with a big home care
division -- and our corporate office is located in
Rockford, Illinois. We are a leader in magnet
recognition for excellence in nursing. Mercy has
been chosen as one of the top premier organizations
nationwide for our integrated care delivery model,
resulting in better patient outcomes at lower costs.

This isn't us saying it. It was attested to
and it was determined by the United States
Department of Commerce, who selected Mercy and
categorized Mercy as what they called a world class
organization getting world class patient benchmarks.

The Department of Commerce chose Mercy
Health as only the 76th recipient among all
organizations and company types, not just health
care, nationwide. So over 20 years, among thousands
of organizations reviewed and studied by the
Department of Commerce, they chose Mercy, under
a program enacted by Congress, to be the
76th recipient of the Malcolm Baldrige National
Quality Award, which was presented by the president
of the United States in the Oval Office.
And I'm not sharing this to toot Mercy's own horn but, rather, just so you know that when I bring a proposal to you, I want you to know that we've studied it; we've examined it from every which way possible. I want you to have confidence in the proposal and that we know how to improve the care for these 50,000 people at Crystal Lake, especially their access to emergency care and stabilization. And many of the people that we give that quick access to at the emergency room, they'll be stabilized and then we'll be sending them back or sending them to one of the area hospitals for longer-term convalescence, a more comprehensive hospital.

But our permanent accountable care model has allowed us to provide this coordinated care approach, and our success is based on efficient coordination of physicians, hospitals, and ancillary services, all geared to one medical record.

We have decades, as I said, of experience successfully and profitably operating these small hospitals in Harvard and Lake Geneva, Wisconsin. Both of them are profitable, and we -- have been profitable since three years after we opened them.
We use evidence-based medicine, best practice standards, industry benchmarks, and a culture of continuous improvement.

But a truly integrated model of care, which is what an accountable care organization requires, under President Obama's Affordable Care Act, requires a hospital, even a small hospital. You've got to finish the continuum of care.

And so the patients in Crystal Lake, if you approve this proposal, will get the benefits of a multispecialty clinic, which is like one-stop stopping. It's very hard for elderly people to go to multiple locations, especially when they have variance in transportation. It's far better for them to get around to one location, be able to see their primary care doctor, the specialists, get their tests, and, if they need a procedure, get the procedure. And if they need to be stabilized because they're 90 years old, they can be stabilized.

That is the way health care should be delivered, and that's the way we deliver it at Harvard. That's the way we deliver it in Lake Geneva and our other facilities.
You know, we -- our competition has talked about the fact that -- I'd like to just point, if I could, to the first chart here and to show you the need to help put it in perspective -- if you could flip that one around.

So you can see we have two communities. The first one is Crystal Lake, and there's 51,000 people -- just over 51,000 -- within a 3-mile radius of our proposed location. The other community is Janesville, Wisconsin, which is where I began my tenure with Mercy 30 years ago. Janesville has just over 50,000 people.

The people in Crystal Lake have access to no emergency care. The people in Janesville, Wisconsin, have access to two hospitals and three emergency rooms, and all three of those are profitable. They're not all Mercy's. They're Dean Clinic, a 500-physician group out of Madison. But all three of those are profitable and the two hospitals.

And so you -- put it in perspective. I mean, in Janesville, if you want to go up there -- and some of you, I think, have been up there. Minimal traffic delays.
Try -- as the patients and the residents
told the physicians -- or the PhD that did the study
from Purdue, the traffic delays on Highways 14 and
30 throughout Crystal Lake are just enormous. They
have rush hour delays there because of Chicagoland
traffic that's unbelievable.

Now, you know -- I mean, I can go on into
numerous cases. I can go on into cases of little
kids that fell off the bike, hit their head on the
concrete, get a subdural hematoma. And if they
can't get to an emergency room quickly and get the
blood released, they end up a vegetable. If they
can get to the emergency room quickly, their --
total recovery.

It just -- it's -- I'm sorry. But in 2017
this first chart should not exist. If you're a
stroke patient, we have medicine today that, if you
have a stroke and you -- if you start hemorrhaging
in the brain -- which that's where the stroke is --
if you can't get the medication, the clot-busting
medication, fast enough, then you're going to go
ahead and bleed out. You're going to die or you're
going to have severe long-term disability from a
stroke patient.
Stroke patients will be able to get to our emergency room, evaluated quickly, get the medication, and then we'll be able to send them to one of the four area hospitals for a longer-term stay.

So what we're proposing in this little small hospital is, when we have a patient come in for a simple procedure, most of them will be sent home because they're healthy. But if they're elderly, if they're compromised, their health, we want to be able to -- we have to be able to stabilize them overnight. Or if they come into the emergency room and they need to be stabilized, we can stabilize them overnight.

That really is the way health care is being delivered today, and that's why Dr. Dorsey called it the first line of defense for those 50,000 people. We're not going to be replicating what the Centegra hospitals do or the Advocate hospitals. We'll be referring to them.

And as was attested to earlier, we've done this study. And this -- even modern health care. In Crain's articles it said, "How threatening can a 13-bed hospital be to these gigantic systems of
Advocate and Northwestern?" I mean, this is about health care and getting it to these people that don't have the access.

And so -- anyway, Barb, I think if you can throw the next chart up.

This next chart shows, I believe, that, in the state of Illinois, there's 187 emergency rooms -- I believe I'm right. 187 emergency rooms. And 128 of those will be the same as our emergency room, a comprehensive emergency room. Only 57 are trauma centers.

But according to the 2015 information from the State of Illinois, 97 percent -- 97 percent of all emergency cases are treated in comprehensive emergency rooms. Only 3 percent of cases require a trauma center. So we'll be able to treat all of the same type of emergencies that the other 128 emergency rooms in the state treat or 97 percent of all the cases.

And you heard Dr. Jay MacNeal say -- who has taught or -- yeah -- teaches paramedics and EMTs in a 15-county area. They're trained to screen people. So when they pick up a person at home or on the street, they know the appropriate hospital to take
them to. They'll know if they should take them to our emergency room or if they need to take them to a trauma center.

I moved along quickly here, kind of summarizing.

Wow. I really gave you guys a brief, short summary here.

I guess I would say, just to pretty much wrap it up, that -- I already talked about that we're going to have less than 2 percent of the admissions and less than 2 percent from the other hospitals and that they'll -- many of those patients will be sent back.

So I think what I would probably like to summarize with is that there's been some arguments by Centegra today that this project will have a financial and negative impact on them. And I already said that this project isn't going to make a difference. They've got -- there's other reasons why they're suffering, but their suffering has nothing to do with the fact that they built Huntley or that this project occurs.

And -- but remember, also, that they're merging with Northwestern. And Northwestern's one
of the best, but it's also one of the largest and wealthiest health systems in the state -- and I just looked it up. Northwestern, as a system, has a net income of over 7 million -- $700 million a year, over 700 million a year, and they have 5 million in cash. So Northwestern has over $5 million in cash in reserves.

MR. MORADO: I'm sorry. Can you please keep your comments focused to the project?

MR. BEA: Yeah, I am -- I am.

So what I'm trying to say is I don't believe that this project is going to threaten the viability of Centegra because they're going to be well taken care of.

And Northwestern, as a system, has -- does less than 10 percent Medicaid. Mercy Health, as a total system, has the largest Medicaid outside of Chicago. We do 20 percent of our patients -- 22 percent of our patients are Medicaid, as a system, and another 9 percent charity. That means 31 percent of Mercy Health's population, patient population, is either Medicaid or charity. Almost a third of our patients are Medicaid and charity.

And Mercy Health is not just helping people
with their medical needs. For 21 years we've operated -- I'd like to share this with you -- a homeless center for women, children, and families. It's not a shelter but a center that provides comprehensive services.

The House of Mercy has helped over 5,000 homeless women, children, and families get back on their feet. And twice the American Hospital Association has given national recognition for Mercy's homeless program.

So our history, our mission, has always been to serve the people that others really do not want to serve -- others don't want to serve -- and, frankly, in areas that other health systems don't want to be in.

This 13-bed hospital is going to allow us to provide accessibility to emergency room services for the over 50,000 people who do not now have that, and that's especially the most vulnerable, the Medicaid, the charity, the indigent, and the elderly.

And you heard one speaker come up and say that there's over 11,000 of the elderly that she helps in Crystal Lake alone. I could tell you that there's over 7,500 Medicaid and charity, so we're
getting up now to about 40 percent of the population falls into that vulnerable category of Crystal Lake.

And, again, the studies show that -- the health study showed from McHenry County their biggest barrier to care is transportation. That's why we need to get that dot down there in that big circle, that first big circle -- if you would put that back up, Barb.

So I'd like to just share with you from an impact standpoint that our little 13-bed hospital, while making a world of difference on the residents at Crystal Lake, is not even going to be a rounding error on Northwestern-Centegra's bottom line.

And our proposed project is a unique project, it's an innovative project, and it's been designed to specifically meet the needs of Crystal Lake. We spent a lot of time -- the unmet needs, I should say. The unmet needs.

A lot of those Crystal Lake people, they're still going to be going to those other four hospitals. They're going to be sent there by us when they need it. We're just trying to fill the unmet need portion of Crystal Lake.

We at Mercy Health and the 50,000 people of
Crystal Lake would be very thankful for your approval.

Thank you very much.

CHAIRWOMAN OLSON: Thank you.

MR. WEBER: Madam Chairperson, I would like to now just respond to the six negatives in the State agency report.

And in the interest of getting to discussion quickly, which I know you want to do, I'd like to consolidate these into the four causes of these six negatives.

Number one, for the negative on performance requirements, during our planning we were fully aware of the regulation that new hospitals proposed in a metropolitan statistical area with medical/surgical units should have a minimum of a hundred medical/surgical beds and four ICU beds. You've heard a lot about this today. Our project clearly does not meet this requirement.

In our discussions with State staff, former State staff going back several decades, and other experts involved in the certificate of need program, none of us could explain the basis and the current relevance of the standard.
As Tracey Klein mentioned, 100 of the 184 hospitals in Illinois that have medical/surgical units have bed complements, med/surg, under a hundred. 26 of these 100 hospitals are located in metropolitan statistical areas.

The opposition has made a big deal about Mercy not meeting a standard. This standard was adopted -- let's look back a little bit -- at a different time in Illinois health care, at least 35 years ago, when length of stay was more than double the current stay, when some patients staying two weeks -- were staying two weeks then and now are being treated on an outpatient basis.

And, Mr. Sewell, when a planning standard was four beds for a thousand population -- you and I in our younger careers remember those days. Those are long gone. That was when larger hospital size was needed.

35 years ago was a time when hospitals were paid on the basis of cost. Whatever the cost of care, that was what the insurance companies -- the reimbursement paid. That was before prospective payment by DRGs was instituted in the early 1980s, before the introduction of managed care in the
1990s, and before the tremendous shift to outpatient care over the past three decades, resulting in significantly smaller inpatient bed units.

Mercy sized the project to fit the community, not the old standard. We hope you put it in this context since the majority of Illinois hospitals are now under 100 beds for med/surg. Mike appropriately made a negative finding based on the regs, but nothing in the standard requires the Board to reject the proposed Mercy project.

You may also be thinking that the Mercy project is a long way from a hundred beds with the proposed 11-bed med/surg unit. As you read the permit application, average daily census is forecast to be 10 patients in the 11 beds. This forecast is based on the number of persons in the office practice panels of 16 primary care Mercy Health physicians officed in Crystal Lake and surrounding communities, already part of the Mercy system.

Again, statewide data show that a medical/surgical service of this size is not an anomaly. Of the existing 184 hospitals in Illinois with med/surg units, 57 have an average daily medical/surgical census of 10.0 or less. That's
over 30 percent of the 184 hospitals. So as you think about the project, please know that it is not out of line with census experience at many, many hospitals throughout Illinois. That was the first point and the longest.

Second, two negatives are associated with the project's impact on other area providers and the duplication of service.

The projected 780 admissions will be drawn from other hospitals. The permit application proposes that, if these admissions were to come from five area hospitals -- and let's face it; probably the Crystal Lake residents and nearby community residents go to beyond the five, but we used five just as an example -- this would be 156 admissions per year from each of the five. 156 divided by 52 weeks in a year is 3, so that would be 3 per week at each hospital.

Similar small projects are associated -- similar small impacts are associated with ER visits, outpatient surgery, and diagnostic testing. It's an impact, yes, but certainly not significant, and the trade-off is that Mercy Health patients would receive coordinated care within a Mercy system, not
fragmented as it is now. We hope you think the trade-off is worth it.

Mercy's system would then be able to provide the coordinated care that systems like Advocate, Centegra, Northwestern, and Presence have established. Our patients want the same from us.

Number three, there is a negative on planning area need because the A-10 area in McHenry County has a computed excess of 43 medical/surgical beds and 3 ICU beds. Because Mercy's project is the relocation of beds in the county from Mercy's hospital in Harvard, it does not affect the excess. People have said that the current excess is due largely to Centegra Hospital in Huntley. Please don't hold Mercy accountable for that project.

Fourth and finally, Mercy's projected ICU bed utilization is responsible for two of the six negatives. We consciously added a second ICU room only to accommodate the anticipated times that there will be a second patient requiring intensive care. Please consider this second bed as essential for quality medical care.

The second negative related to the ICUs is the assurance letter that Mr. Bea signed. The
letter affirms that Mercy will meet the occupancy
standard for med/surg beds. Mercy could not attest
to meeting the ICU bed standard because of the point
just made.

The project meets all other standards.
Clinical services meet all size standards. All
except ICU meet the utilization standards. The
entire project meets the State's construction and
cost standards.

Please do not misunderstand. We are not
casual about the State's standards and regs, nor are
we asking you to be as you exercise your judgment
and Board discretion.

In closing, I want to express our
appreciation to staff for their guidance as we
developed our permit applications.

CHAIRWOMAN OLSON: Thank you.

MR. WEBER: Thank you.

MR. BEA: That's all of the prepared
remarks --

CHAIRWOMAN OLSON: Okay.

MR. BEA: -- but we're open for questions if
you'd like.

CHAIRWOMAN OLSON: Sure. Sure.
Questions from Board members?

Mr. Sewell.

VICE CHAIRMAN SEWELL: Yes.

I wanted to talk about this performance requirement. You know, I don't know, either, why this standard exists the way it does, but it is the standard. The way you deal with something like this, I think, is sort of a collective interplay between this Board and the provider community should revisit the standards from time to time.

You went through a whole history of reform in the system with prospective payment, rise in managed care, and all that. And while this was a standard before all that, it seems like, in all this time, somebody should have said, "Well, why is there a requirement for an MSA you've got to have a hundred-bed minimum hospital?"

But -- I think that this Board has been reasonable about responding to suggested changes to the standards. So the problem with, I think, your argument is that, even though it's an old standard, it's the standard.

And maybe sometime, through all those years -- I believe it was -- what, 1983? You know,
at some point we probably should have been challenged and maybe -- in revisiting this. And I'm saying this without knowing why we have the standard. I don't know. Maybe it's because of the existence of critical care hospitals and they didn't want those in an MSA -- I don't know. That's one thing.

The other thing I guess I wanted to hear -- I think you're saying that the two intensive care beds are there just for quality care because, you know, if you just had one, you'd have no flexibility in those instances where there might be another patient. I think I get that.

But it looks like what the -- I don't want to put words in Mike's mouth. It looks like it's the failure to provide documentation to justify the two. Is that -- I guess I'd turn the question to the staff.

You're saying here that the Applicant was unable to provide documentation that the two intensive care -- two-bed intensive care unit will be at the target occupancy.

MR. CONSTANTINO: Yeah. They couldn't provide the number of referrals required.
VICE CHAIRMAN SEWELL: I see. And that's a little different than the issue of having flexibility to enhance quality of care.

MR. WEBER: Yeah. Mr. Sewell, I want to make sure that, really, the -- the way you asked the question was -- provided -- didn't provide the documentation to support the justification.

We did provide the documentation. And, you know, the ratio of intensive care unit patients to med/surg patients, I think we went all through that very analytically in the permit application.

The second part of it is it doesn't justify the utilization. As you know, ICUs are -- 60 percent utilization is the standard. I think we have 126 patient days, if I remember. That's about 34 percent so one justified.

And the way the staff does the work is, if you've got one unit, even if it doesn't get up to the threshold, you meet the standard. But if you add a second one, then you don't.

So we had a dilemma. Do we just do one and meet the standard? And what do you do, then, with the 30 or 40 times a year when you've got a second patient in the hospital requiring intensive care?
So we looked at the Walworth experience -- again, similar-sized hospitals -- and the ratio of beds there, and that's where we came up with this 30-or-so times a year that it was going to be needed.

So we had to make a decision. We knew we were going to get a negative, but sometimes doing the right thing is more important --

VICE CHAIRMAN SEWELL: No, I get it.

MR. WEBER: -- than making the standard.

VICE CHAIRMAN SEWELL: And the final thing I had was about the bed -- the unnecessary duplication of service. It's almost like we're talking about Centegra as a project instead of an existing hospital that's in the inventory.

Do you see what I mean? Or will be.

And so, you know, this standard is not met because of what we know. It's not like the opponents of the inventory are going to be proposing at some point in the future.

MR. WEBER: Sure.

VICE CHAIRMAN SEWELL: It's there. So I think that's a valid finding by the State agency staff on your project.
And this thing about innovation, you know, in terms of, you know, very small hospitals -- you know, I think you could probably always calculate the kind of -- the number of beds that would respond to what your vectors are that create demand, but that's not all there is.

There are other things, and I think this sort of takes everything into consideration. Now, we could argue with this hundred-bed issue in an MSA as an artifact or something from a bygone era, but all of us, I guess -- this Board, the provider community -- had quite a while to look at that and say, "I wonder where that came from."

So that's all I have.

CHAIRWOMAN OLSON: Other questions or comments?

Doctor.

MEMBER GOYAL: Thank you, Madam Chair. My name is Arvind Goyal, and I represent Medicaid on this Board, and I do not vote.

So my questions are -- I did not see in your application or any presentations if you're doing any OB, pediatrics, or behavioral health. Could you amplify that?
MR. WEBER: There is -- yeah.

There is no OB or pediatrics in this -- very much this project is a translation of what are the existing programs at the Harvard Hospital. There is no OB there or pediatrics.

Behavioral health is something that Mercy is very much looking at. They have a behavioral health outpatient program, an individual -- I think you heard from her at -- in the -- at Harvard. And they are looking at that because that is a significant need in the community.

MR. BEA: We have pediatric outpatients, just not inpatient.

MEMBER GOYAL: Right. I understand.

So looking at your Medicaid projections of 11 percent -- I think I saw that.

MR. WEBER: Yes.

MEMBER GOYAL: May I have you project a little bit further and see where that Medicaid portion of the population you serve as inpatient will come from?

MR. WEBER: We know that resident -- there are 7500 residents of Crystal Lake who are Medicaid. The broader Medicaid place of McHenry County is a
very healthy 49,000. In fact, I think I saw 52,000
in a figure yesterday for year 2016.

I think that -- when Javon Bea mentioned
earlier the largest Medicaid provider outside of
Chicago, I think he meant that at the Rockford
Memorial Hospital they have the largest percentage
of Medicaid at Rockford.

Is that -- or is it the system?

MR. BEA: The total system, yeah --

MR. WEBER: Total system.

MR. BEA: -- parts in Rockford.

MEMBER GOYAL: I didn't understand the last
thing you said about second largest --

MR. BEA: We're the largest Medicaid
provider outside of Chicago as a total system,
22 percent Medicaid, 9 percent charity, as a total
system.

But a good portion of that is in Rockford
and also at Harvard. And a good portion is
elsewhere, too.

MEMBER GOYAL: In absolute numbers that is
probably not true. But let's leave that alone; it's
not relevant.

But I have two other comments to make. One
is -- or a question first.

Do you participate in all Medicaid MCO plans at this time?

MR. COOK: Yes. Yes, we do.

MR. BEA: Yes, we do.

MEMBER GOYAL: All 12 of them?

MR. COOK: Yes.

MEMBER GOYAL: Okay.

THE COURT REPORTER: Who are you, please?

I'm sorry.

MR. BEA: John Cook is the CFO.

THE COURT REPORTER: Thank you.

MR. BEA: He's saying, yes, we do, all 12 of them. We participate in all MCO Medicaid plans.

MEMBER GOYAL: Okay. Good.

Now, you have two operating rooms from what I understood.

MR. BEA: Yes.

MEMBER GOYAL: And you have two ICU beds?

MR. WEBER: Yes.

MR. BEA: Yes.

MEMBER GOYAL: And your emergency room in addition?

MR. BEA: Seven stations, yes.
MEMBER GOYAL: So I'm going to take a little
different tack.

Do you think that your two ICU beds are
enough in cases where both of your operating room
patients might need intensive care?

MR. BEA: I'll let Jeni probably talk on
this a little bit more. But, basically, we took
this very much out of the two similar hospitals that
we've been operating for decades at Harvard and
Lake Geneva.

And so the type of cases that we bring in
that we do surgery on through the prescreen -- we
don't seek out cases there that are going to require
a lot of intensive care. That's more when a patient
comes into the emergency room and needs that.

But I'll let Jeni go ahead and comment on
that.


Every facility with high utilization always
runs the fear of "What if you need that one more
bed?" and it certainly stands true for the ICU, as
well.

In our planning we felt as though our
volumes could easily justify, as Ralph had
explained, the one ICU bed. We felt it necessary to have the duplication of a second in that -- in that event that we needed a second. And there may be a time when we need a third, and we would certainly, as Mr. Bea had indicated, appropriately care for the patients in that facility.

And if somebody were to come and still need that intensive care and be on a ventilator, then we would continue to work closely with our providers and other area hospitals to provide the care to that patient.

MEMBER GOYAL: So I wanted you to really say that. You heard from your area hospitals?

Do you think you will go in the neighborhood where you will get any cooperation from your area partners? Or would you have a tertiary backup of any kind?

MR. BEA: Yeah. I mean, right now our doctors that are going to be on staff here are on staff at those hospitals. You've heard them attest to that themselves. So our doctors are all on their medical staffs right now, so, of course, there would be that backup. Our doctors can choose to admit to those hospitals versus this small hospital.
We really are trying to get the emergency services in Crystal Lake, and we need to have those 13 beds to be able to stabilize somebody overnight or for less complicated surgery when someone needs to be stabilized overnight. That's really the point of it.

But if our doctors see that someone's going to be -- that they need to get to a more comprehensive hospital, they're already on the staffs at those hospitals.

MEMBER GOYAL: Thank you.

CHAIRWOMAN OLSON: Other questions or comments?

MEMBER MC GLASSON: Yes.

CHAIRWOMAN OLSON: Please, John.

MEMBER MC GLASSON: Mr. Udy -- I believe is his name -- and then you reiterated his statistics about Medicare and ACOs.

MR. BEA: ACO, yes.

MEMBER MC GLASSON: Bear in mind what Mark Twain said about statistics.

Do you actually expect to be able to deliver quality -- better quality care at lower costs than the --
MR. BEA: I don't --

MEMBER MC GLASSON: -- other hospitals in

the area?

MR. BEA: Yeah, I don't mean to be --

whatever. I don't expect that we'd be doing that.

As attested to by the ACO reporting by CMS, we've
been doing it. And that's why we received national
recognition for being one of the only health plans
to be able to lower our premiums to the exchange
subscriber. We've been doing that.

MEMBER MC GLASSON: Thank you.

CHAIRWOMAN OLSON: Joel.

MEMBER JOHNSON: Back to, I think, a point

Mr. Sewell was making -- I just wanted to make sure

I understand.

Unnecessary duplication. Is it your

position that, with the creation of the beds in this

application and the reduction of the beds in

Harvard, that, essentially, it's a shift of beds,

and, therefore, the duplication exists already which

exists and, if anything, you're making it better?

MR. BEA: Yes. We -- that's exactly right,
sir. We're moving them to where they're more --

most needed. That's right.
MR. WEBER: Let me -- Mr. Johnson, if I could add to that related to duplication of service is the criteria called maldistribution. And we think of that in two ways in a mini activity in the Mercy system. The beds are in Harvard. They needed to be -- they're not being utilized as much in Harvard. So I've heard, in our planning meetings, a maldistribution of the Mercy Health beds.

But the broader and the appropriate regulatory definition of "maldistribution" includes a statement that says "Maldistribution exists when the ratio of beds to thousand population is 1 1/2 times the State average." In McHenry County, Planning Area A-10, those ratios are less -- not 1 1/2 times but less than State average.

The -- I had them here moments ago but -- here they are: Med/surg in Illinois, 1 med/surg bed for 593 residents. In McHenry County, 1 per 1123. ICU is, in Illinois, 1 per 3700 roughly. In McHenry County, 1 per almost 8,000 residents. So that should fit into your thinking about maldistribution.

MEMBER JOHNSON: A follow-up question: With this -- I appreciate the cost of construction and
the fact that this project comes into the scope in
terms of the financials.

But for the number of beds proposed for this
project, is there thought of future growth and
expansion within the walls of this facility? And
how will that impact the planning area?

MR. BEA: Yeah. Well, we always, you know,
have our walls so that they're expandable and
there's a lot of -- there's a lot of extra land
around, so it's easy to expand. And I think that
the criteria -- correct me if I'm wrong -- is
10 percent every two years.

But I just can't -- it's hard to emphasize,
unless I get really boring with statistics and
numbers, the movement from inpatient care to
outpatient care.

I mean, I'm a physical therapist. You know,
that's really where I started. And we used to --
when I was treating total hip patients, we kept them
in the hospital for 10 to 12 days doing therapy
twice a day.

I had my total hip done, and I got kicked
out in 18 hours. And I was given a home
instruction, you know, on -- for my physical
therapy.

I mean -- and so that's -- our open-heart procedures today might average between two and three days length of stay. It's just -- the movement from the need for inpatient beds is just -- and the technology just continues to escalate such.

And that's why I give you the example that we could -- and look at all of you. We could do a procedure -- so many procedures that you needed to be in the hospital four or five or six days just not too many years ago, and we'll send you home in a day.

But we get a 90-year-old grandmother in who's got a lot of other metabolic, you know, issues, that's where they need to be watched. That's where they need to be watched longer. So it's just -- the movement to outpatient surgery is phenomenal, and you just don't need a lot of beds.

And I go back to Mr. Sewell's comment about -- I can't emphasize enough that if the Board could stress to the staff or to whoever -- but that standard today that causes providers to say, "Oh, we'd better meet that standard, let's go in, you know, with a high-cost, hundred-bed hospital" --
they're just not needed today. They are not needed.

And so, anyway, to answer your question,
Mr. Johnson, we think that, when we look at our
statistics and growth, that normal statistic allowed
under the regulations of 10 percent in beds every
two years would be more than able to satisfy our
need.

MS. KLEIN: And I think we thought,
Mr. Johnson, that would be 1.3 beds a year. So, you
know, it -- we don't think that there's much danger
that, over two years, that there would be -- this
would open the floodgates to a bigger facility.

The other thing, just to amplify what was
said on duplication and maldistribution, we are not
going to -- whatever we do here, whatever you do
here today as a Board will not change the fact that
there are 43 excess beds unless, with the approval
of this project, if we can run at our 91 percent
occupancy in both facilities, then we estimate that
the utilization of the 13 beds will actually reduce
the excess capacity in the planning area. So we
think that would be a positive thing.

If you don't approve it, we're still going
to have the 13 underutilized beds. Nothing will
change there.

So the other thing that we would also say --

it's interesting because when you're tackling -- and

rightfully so -- you bring up this issue of
duplication. And so I was asking one of our
associates, "Please find the definition of
'duplication.' I want to know exactly what the
definition is." And I can't find one in your
regulations.

But what I can tell you is, if you look at
the dictionary, it says "act or process of doing the
same thing another person has already done." So,
effectively, it focuses on service.

If you go back to Mr. Bea's earlier
comments, we think that this is well within the
purposes of the act because it's going to eliminate
duplication when it comes to services because of the
integrated model of care and the medical -- the
electronic medical record and the ability to engage
in care management.

MEMBER JOHNSON: I'd just tell you to focus
on the word "unnecessary" more than the word
"duplication."

MR. BEA: You could say --
MEMBER JOHNSON: It's "unnecessary duplication."

MR. BEA: That's right. But a lot of that comes from -- the patient shows up, I don't have the test results from the other provider, so I have to do it all over again. That adds tremendously to the health care cost, and there's always a risk to the patient oftentimes.

CHAIRWOMAN OLSON: Mr. Burzynski.

MEMBER BURZYNSKI: Thank you.

Well, first of all, let me congratulate you on being innovative and looking for a different health care model as we move forward here.

Having said that, I do agree with Mr. Sewell relative to the standards that we have in place today. Maybe we all need to sit down and look at those. And I know the legislature has a lot more to deal with on their hands than looking at our rules or whatever, but that's something that we really need to address in the future if that's not an adequate standard today.

Having said that, I've got a couple of questions.

First of all, I think I've heard -- and in
the testimony that was given in the hearing, this was referred to as a microhospital. Now, I also think today I heard that this is not a microhospital.

    MR. BEA: Right.

    MEMBER BURZYNSKI: So can somebody please explain where -- are we just talking about using terminology in a different way or whatever --

    MR. BEA: Yeah. People use that term however they want.

    If you really do a literature search, it's really -- I think the industry is struggling with this idea of the fact that there's significantly less beds needed today. But I think, as you heard Matt Sanders' comment from AECOM who did a national search -- and we've actually contacted organizations that have tried to use that term, contacted some out west that have these throughout the mountains -- what they're really oftentimes talking about are ambulatory care centers with like recovery beds.

    And then there's -- as Mr. Sanders said, lots of times they won't have emergency rooms, they won't have surgery suites, they won't have -- it's really a way to -- and oftentimes they may have an
outpatient surgery and they know that -- remember
the grandmother that needs a longer stay? They'll keep them in for those rare, few patients that need to stay in for 20 hours or 23 hours, to try to stay in there 24 hours -- and they'll have the food service kind of brought in from the outside.

So it isn't an apples-to-apples comparison. That's why that term is really a term that is misused and thrown all over the place. And this -- because it's a -- because we feel that the greatest unmet need in this city of 50,000 people is a lack of an emergency room, we've geared all of our services downstream to be able to deal and offer a comprehensive emergency room.

That's why we've got, you know, the ORs, the procedure rooms, the full diagnostic and radiology, et cetera, to be able to offer a comprehensive emergency room. So this isn't a microhospital, but this is appropriately sized and scaled to the unmet needs.

MEMBER BURZYNSKI: Okay. Because your testimony was where I saw "microhospital" first.

MR. BEA: Yeah. I -- you know, I probably shouldn't have used -- you mean today or --
MEMBER BURZYNSKI: No, at the hearing.

MR. BEA: Yeah. I've been thrashed and adequately disciplined for using that term. And I've had the -- I've had that literature brought to me, and so I stand corrected.

MEMBER BURZYNSKI: Just a couple of other things very quickly.

You know, you're not -- you're really not asking us to approve one hospital that doesn't meet those standards that we've already got in place, but you're asking us to have two hospitals because you would have the Harvard Hospital, as well, as the second hospital that wouldn't meet that bed -- minimum bed requirement.

MS. KLEIN: I think -- I don't think that's actually correct because Harvard must be out of the MSA, and that rule applies only as wide as the MSA --

MEMBER BURZYNSKI: You're right, yeah.

MS. KLEIN: -- because it's a critical-access hospital.

MEMBER BURZYNSKI: Critical access.

MS. KLEIN: Yeah.

MEMBER BURZYNSKI: And that was another
question I had. What does this do to the critical-access status of the Harvard hospital? Anything at all?

MS. HALLATT: Doesn't affect it.

MS. KLEIN: Doesn't affect it.

MR. BEA: Doesn't -- nothing at all.

Doesn't change it.

MEMBER BURZYNSKI: And then I did have one more, and I think it was touched on very briefly.

But would there be -- can you add additional beds at Crystal Lake in the future without coming back to this Board?

MR. WEBER: The -- could I speak to that?

MR. BEA: Sure.

MR. WEBER: There's a 20-bed rule -- and this is more current than the ancient rules. There used to be a 10-bed rule that, in a period of 24 months, you could add 10 beds. That was expanded about 8 years, 10 years ago to 20 beds or 10 percent of a service, whichever is less.

So with an 11-bed medical/surgical service or a 2-bed ICU service, that's like 1.3 beds, as we talked about before, every two years.

So it would take a lot of -- this is not a
foot in the ground to build a big hospital. It
can't be done.

MEMBER BURZYNSKI: Thank you.

MR. MORADO: I'll just speak to that,
Member Burzynski.

He's absolutely correct. It's 10 percent or
20 beds, whichever is the lower amount.

I would also like to note -- it sounds like
it's a concern whether the 43 excess beds -- if the
Board was inclined to do so, they could place a
condition on the permit itself with a set condition
for a set period of time saying that the Applicant
would have to come back before this Board if they
wanted to add additional beds in the future.

Now, of course, it would be incumbent upon
the Applicant to either accept that condition or not.

MS. KLEIN: Senator, just to amplify, too,
on your question, we did quite a lot of research
regarding this project, and there are health
systems -- large health systems all over the
country -- that are looking at this whole concept
of -- some places they call this more a small format
hospital.

One of the things that you probably noted
from Mr. Bea's testimony is that, in addition to the surgical suites, the procedure rooms, there's a full suite of imaging in this facility, a full laboratory, an in-house pharmacy. So one of these small format or small hospitals is not the same as the next. That's what we've learned for sure.

And the -- this is truly a small -- we decided -- it was a small hospital, in keeping with the other model that has been used by Mercy very successfully.

CHAIRWOMAN OLSON: So I just want to make sure -- Mike, this is for you because much has been made here about the cost of this project.

But they met all the criteria related to cost and financial --

MR. CONSTANTINO: They met the gross-square-footage cost, yes.

CHAIRWOMAN OLSON: And then back to Juan's point, so -- if I understand correctly, if they were at 91 percent utilization, they could add 1.2 beds every two years if they met that utilization threshold?

MR. MORADO: I don't think they need to meet the threshold.
MR. CONSTANTINO: No. There's no utilization threshold.

MR. MORADO: They could come in every two years and add either 10 beds --

CHAIRWOMAN OLSON: But what you're -- I think what you're saying there is that's not the intention. But would you be willing to come back to the Board if you --

MR. BEA: Yeah, if you want us to. I mean -- you know, in other words, one bed every two years is not --

CHAIRWOMAN OLSON: Yeah.

MR. BEA: It's not going to have an impact. If you want us to stay here for time for that, we'd be willing to adhere to that condition. But, certainly, we don't have any intention to come back and say, "Oh, geez, we need to add" -- you know -- "50 beds or 20 beds" -- whatever. But we're --

CHAIRWOMAN OLSON: It doesn't sound like that's your model anyway.

MR. BEA: Yeah, right. We're open either way. We're open either way.

We can just stay with the one bed every
two years or, you know, if we need an extra bed, we can come back to you every two years, to the Board -- or not. It all depends on the need.

CHAIRWOMAN OLSON: What -- does anybody have any thoughts on that, or is that not really relative?

(No response.)

CHAIRWOMAN OLSON: No? Okay. Just throwing it out there.

Other questions or comments?

(No response.)

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

MR. ROATE: Motion made by Mr. Johnson; seconded by Senator Demuzio.

Senator Burzynski.

MEMBER BURZYNSKI: I really -- I've looked long and hard at our staff report and recommendations, and they do -- you know, there's some valid issues there that need to be addressed.

But I also think some of those valid issues -- the standard for a hundred hospitals [sic], that needs to be addressed, as well, by us looking towards the future.
I do have a few concerns relative to the size, but I think that, certainly, looking at all the information we've been provided with today, I'm going to vote in favor.

MR. ROATE: Thank you.

Senator Demuzio.

MEMBER DEMUZIO: Sorry about that. I have to -- I agree with Senator Burzynski. I think that you've answered some of the questions that we had concerning some of the findings that the staff had. I feel fairly comfortable with that. Your financials are in good shape, so I think that says a lot in terms of where you're at. So I am going to go ahead and vote yes.

MR. ROATE: Thank you.

Mr. Johnson.

MEMBER JOHNSON: I'm also going to vote yes based on the testimony heard here today, primarily in answering many of the issues raised by the staff report. And it does cause us to perhaps take a look at the regs and make sure that they meet today's health care needs.

MR. ROATE: Thank you.

Mr. McGlasson.
MEMBER MC GLASSON: I'm going to vote yes based on the testimony regarding the ability to, hopefully, lower costs in health care.

MR. ROATE: Thank you.

Ms. Murphy.

MEMBER MURPHY: Based on the findings in the report that were positive and based on the Applicant's response to the negative findings and especially the comments from the community in favor, I'm going to vote yes.

MR. ROATE: Thank you.

Mr. Sewell.

VICE CHAIRMAN SEWELL: I'm going to vote no. I think the way this process works is that we change the rules and then we apply them to prospective applications.

MR. ROATE: Thank you.

VICE CHAIRMAN SEWELL: So I vote no.

MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: I'm also going to vote yes based on the fact this is not changing the bed need area in the planning area.

I don't believe that a 13-bed facility is
going to have a huge impact on the larger providers. I think the ED access is necessary. I applaud the access for Medicaid and charity care recipients, and I believe that individuals in that area deserve local access to health care.

So I vote yes, as well.

MR. ROATE: Thank you, Madam Chair.

That's 6 votes in the affirmative, 1 in the negative.

CHAIRWOMAN OLSON: The motion passes.

Congratulations.

(Applause.)
CHAIRWOMAN OLSON: Okay. Moving on, Project H-02 -- do we need a break? Okay.

Now you can cheer.

(A recess was taken from 3:30 p.m. to 3:38 p.m.)

CHAIRWOMAN OLSON: Next, we have Project 17-001, Mercy Health Hospital medical office building.

May I have a motion to approve Project 17-001.

MEMBER BURZYNSKI: So moved.

CHAIRWOMAN OLSON: And a second, please.

MEMBER JOHNSON: Second.

CHAIRWOMAN OLSON: And I believe everybody at the table has already been sworn in.

MR. BEA: Yes, ma'am.

CHAIRWOMAN OLSON: Mr. Constantino, your report.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The Applicants are proposing to construct a medical office building in Crystal Lake. The medical office building will have 42 examination rooms accommodating 15 physicians. Clinical service at the medical office building will include physical therapy, occupation therapy, and infusion therapy.
The total cost of the project is approximately $18.9 million. The completion date is November 30th, 2020.

There were no findings. We did have a public hearing on this project, and there was support and opposition regarding the project.

CHAIRWOMAN OLSON: Thank you, Mr. Constantino.

MR. BEA: Sure. My comments will be very brief because of our extensive discussion regarding the hospital.

This is really the idea of, again, coordinating care. We have five different locations within the city of Crystal Lake where we have these physicians located.

And, again, it's hard on people to try to get to the different locations to see a primary doctor here and then go over to this one for a specialist, so this is the idea of bringing our physicians together for better efficiencies and coordination of care for both the patients as well as the providers.

And we're right now at 43,000 patient visits, and we see that growing to 73,000 patient
visits in this facility by 2022 or two years after
the project opens.

We did specifically, because of the high
elderly population, put in the therapies that were
mentioned, as well as infusion chemotherapy, so this
is going to be, I think, greatly appreciated. It's
going to eliminate duplication of testing between
and among the different facilities, and it's going
to be, I think, very much appreciated, kind of a
one-stop shopping concept.

The other thing it's going to do, obviously,

is have these physicians right next to the hospital,

adjoined to the hospital, so that when they need to
be called to the emergency room, they can see a
patient there.

And as Mr. Constantino said, there were no
negative findings. And we're open for any
questions.

CHAIRWOMAN OLSON: Thank you.

Questions from Board members?

(No response.)

CHAIRWOMAN OLSON: I just have a point of
clarification.

Somebody said earlier that this was going to
be the top two floors of the hospital. But it's
not? It's a separate building?

MR. BEA: Right. It is -- but attached,
part of it, right.

CHAIRWOMAN OLSON: All right.
Okay. Seeing no further questions, I'd ask
for a roll call vote.

MR. ROATE: Thank you, Madam Chair.
Motion made by Senator Burzynski; seconded
by Mr. Johnson.

Senator Burzynski.

MEMBER BURZYNSKI: Yes, based on staff's
report.

MR. ROATE: Thank you.

Senator Demuzio.

(No response.)

MR. ROATE: She's absent.

Mr. Johnson.

MEMBER JOHNSON: Yes, based on the staff
report.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on the
positive report.
MR. ROATE: Thank you.

Ms. Murphy.

MEMBER MURPHY: Yes, based on the staff report.

MR. ROATE: Thank you.

Mr. Sewell.

VICE CHAIRMAN SEWELL: Yes. No findings.

MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: Yes, based on no findings.

MR. ROATE: Thank you.

That's 6 votes in the affirmative.

CHAIRWOMAN OLSON: The motion passes.

Congratulations.

MR. BEA: Thank you very much. Thank you all very much.

(Applause.)

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CHAIRWOMAN OLSON: Next I'll call to the table Project 17-009, Silver Oaks Hospital. May I have a motion to approve Project 17-009, Silver Oaks Hospital, to establish a hundred-bed AMI hospital in New Lenox.

MEMBER BURZYNSKI: So moved.

VICE CHAIRMAN SEWELL: Second.

CHAIRWOMAN OLSON: If I can get the Applicant to move to the table and be sworn in, please.

THE COURT REPORTER: Would you raise your right hands, please.

Would you raise your right hands, please.

(Seven witnesses sworn.)

THE COURT REPORTER: Thank you.

CHAIRWOMAN OLSON: Thank you.

Mr. Constantino, your report.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The Applicants are proposing the establishment of a hundred-bed acute mental illness hospital in New Lenox, Illinois, at a cost of approximately $24.3 million. The anticipated completion date is December 31st, 2018.

There were no findings -- excuse me. There
was no public hearing, no opposition letters. A
number of support letters were received by the State
Board staff. And we did have findings regarding
this project.

CHAIRWOMAN OLSON: Thank you, Michael.

Comments for the Board?

MS. COLBY: Good afternoon, Madam Chairman,
and good afternoon, members of the Board.

My name is Ruth Colby, and I'm the chief
strategy officer at Silver Cross Hospital, and I'd
like to introduce the team that's here with me
today.

To my right is Mr. Edward Green, counsel to
Silver Cross from Foley & Lardner. To my left is
Dr. Richard Kresch, who is the CEO of US HealthVest.
Next to him is Martina Sze, who is the executive
vice president from US HealthVest.

Next to her is Mark Silberman, counsel to
US HealthVest from Benesch. Next to him is
James Cha, chief financial officer from
US HealthVest.

And at the end is Dr. David Mikolajczak, who
is the medical director of EMS, emergency medical
services, Region 7, and an emergency room physician
at Silver Cross Hospital.

So thank you for the opportunity. We feel very privileged to be before you today to bring Project 17-009, which is to build a hundred-bed psychiatric hospital on the Silver Cross campus in New Lenox, Illinois.

I'd like to provide just a quick, brief overview of the project. We know you've had a long day. And I will address some of the limited findings in the State agency report, and then Dr. Kresch will speak about US HealthVest and the Illinois operation at Chicago Behavioral Hospital in Des Plaines. And then, lastly, Dr. Mikolajczak will talk about the impact of the mental health crisis and how it's affecting emergency departments in EMS Region 7.

As our application details, there is a dire need for mental health services, not only in Planning Area A-13 but across the entire country. One in four Americans suffer from a mental health condition.

Silver Cross Hospital's been an active participant in the Will County Department of Public Health's collaborative to assess the needs of the
community, and year after year the number one need
is -- that's not met -- is mental health services.

Our emergency rooms in the community are
filled with people waiting for placement. In fact,
70 percent of the health care providers that were
surveyed said they refer people with mental
illnesses to hospital EDs because of access issues.
There's absolutely nowhere else for people to go.

The court system has cried out to hospitals
in Will County. They basically said, "Help us.
Help us provide safe quality, high-quality services
for people that we care for." They pleaded with us
to do something transformational in the community.

As documented in the application, there are
75 acute mental illness beds in Planning Area A-13,
which has a population well over 700,000 people,
resulting in a ratio of 10.5 beds per hundred
thousand people. In Illinois the ratio's closer to
35 beds per hundred thousand and, in the literature,
mental health experts recommend a ratio closer to 40
to 50 beds per hundred thousand.

We're not challenging the Board's
calculation of needs; we're merely highlighting the
crisis that we're experiencing in the community. It
is real and it's having a devastating impact on
patients, families, health care workers, emergency
medical providers, physicians, police, and the
jails.

Silver Cross has had a 20-bed inpatient
mental health unit for many years, and it's just too
small. We're not able to accommodate all the
specialized services that really cross the continuum
of care in mental health. As you know from working
with us over the past -- oh, I don't know --
12 years, it's been our position to partner with the
best of the best.

That's what we did with pediatrics with
Lurie; it's what we did with Northwestern in
neurosciences; it's what we did in oncology with the
University of Chicago. And that's exactly what
we're bringing to you today in mental health
services, by partnering with US HealthVest.

Learning about the work that US HealthVest
has done at Chicago Behavioral Hospital prompted a
conversation with their leadership, and, thus, a
joint venture partnership was created to expand
services. I personally have visited Chicago
Behavioral Hospital and was extremely impressed with
the culture, the interaction between patients and staff, and the dedication of the leadership team.

Our chief nursing officer, our chief operating officer, and our vice president of human resources made unannounced visits to Chicago Behavioral Hospital and felt exactly the same way. We can confidently say that it's our privilege and our honor to be co-Applicants with US HealthVest and have them run the Silver Oaks Psychiatric Hospital on our campus.

US HealthVest has made strong commitments to serve all patients, regardless of their ability to pay. Mayor Baldermann had hoped to be here this morning -- he was going to be here at ten o'clock and it got switched to 11:00, and he couldn't make it. But he instructed me to tell you that the Village of New Lenox welcomes this hospital. He personally has met with Dr. Kresch, and the zoning is in place for it to be on our campus.

Over 100 agencies, schools, legislators, Judges, fire chiefs, police chiefs, social workers, physicians provided letters of support to demonstrate the need for this hundred-bed hospital. Not one letter of opposition was received for this
And we understand that according to -- Administrative Code 1110.730(c)(3)(b) requires that they have zip codes attached to patients for referrals as well as letters signed by physicians. Many of the referring agencies do not collect this kind of information. We've reached out to all of them; they've confirmed their commitment. We know that sometimes physicians are not the only people that refer people to a psychiatric hospital.

In fact, last week we submitted an affidavit from the medical director at Chicago Behavioral Hospital where he stated that less than 1 percent of the inpatient referrals to that hospital come directly from a doctor. Instead, 99 percent of the referrals come from other hospitals, crisis social workers, and other nonphysicians.

I'd like to emphasize again that there was no opposition to this project.

Lastly, I wanted to touch on the negative findings on some of the financial ratios for Silver Cross and US HealthVest and the joint venture organized. Please understand that those technical ratio issues will not impact this project. As the
Board staff stated in the State agency report, the Applicants have the cash, the funding available to start and finish this project on time without any delays.

Of all the projects over the years that Silver Cross has brought to this Board, from the new hospital to the professional office building to the cancer center and, most recently, the ambulatory surgery center, in my mind this is the most important application and will have the most positive impact on the community we serve.

We have the vision, we have the commitment, the resources, and the desire to see Silver Oaks Hospital become a reality. And, most importantly, the community and residents in Planning Area A-13 are depending on us to do this.

So now I'd like to ask Dr. Kresch to say a few words about Chicago Behavioral Hospital.

DR. KRESCH: Good afternoon and thank you very much for taking the time to hear us today.

I am Dr. Richard Kresch, a psychiatrist and CEO of US HealthVest. I've had the privilege of being -- appearing before this Board before and am pleased to bring another project to Illinois to
serve those suffering from mental illness and
addiction issues.

Chicago Behavioral Hospital was approved for
a change of ownership by the Board in 2014. Since
the Board's approval, we have committed significant
capital -- made a significant capital investment in
the hospital and have expanded our service offerings
to include care to all -- patients of all ages, from
adolescents on through seniors.

When we acquired Chicago Behavioral Hospital
nearly three years ago, there were only four
patients being treated in the hospital. Today, the
hospital has average census of almost 125, hovering
around that number, and has been running at
90 percent occupancy.

We are just as confident about the prospects
for Silver Oaks Hospital. Indeed, the support for
this project has been overwhelming. No opposition
of any sort has been put forward.

As Ruth said, we are committed to serving
all patients, regardless of their insurance or
ability to pay. We are thrilled with the response
from the Silver Cross emergency department and
will ensure a continuity of care between the two
facilities. Both Silver Cross Hospital and
US HealthVest are dedicated to ensuring that
patients receive care at the right place at the
right time every time.

My management team has worked together for
over 20 years. We understand the needs of patients,
and we serve the special needs of diverse
populations. It is our plan to dedicate units
within the hospital to pediatrics and adolescents,
to women who have suffered traumatic events, to
senior citizens, and to those suffering from
substance abuse in self-contained areas with
specialized staff. Our design allows for
flexibility in number of beds and number of units
based on the needs of our patient cohort.

We will support patients once they have been
discharged from the hospital. We have held numerous
meetings with community agencies and follow-up care
resources to ensure that the discharge back into the
community is a smooth and effective one.

At the same time and for the purposes of
full disclosure, we hope to deliver the same quality
program to the Northbrook community, but we have
faced some unexpected zoning problems in that city.
US HealthVest has just filed a status report to the Board and will continue to advise the Board on the status of that application.

Fortunately, from a zoning point of view, Silver Oaks Hospital will sit in a hospital district, and those special district zoning regulations in New Lenox clearly allow for the construction of Silver Oaks Hospital.

Now, I'd like to turn the microphone over to Dr. Dave Mikolajczak. Dr. Mikolajczak is the director of emergency medical services, Region 7, and an emergency room physician at Silver Cross. Dr. Mikolajczak is also a member of the Silver Cross Hospital board of directors.

DR. MIKOLAJCZAK: Thank you.

Good afternoon and thanks for giving us the opportunity to speak to you today. As mentioned, I'm an emergency physician and I practice currently at Silver Cross about 35 hours a week, and I want to let you know that I'm strongly in favor of the proposed 100-bed hospital on the Silver Cross campus.

EMS providers know firsthand what the crisis is in our community revolving around mental health
and addiction patients and the difficulty in getting
these patients placed appropriately in the current
health care atmosphere. The promise that we made to
bring these patients directly to Silver Oaks
Hospital, knowing they'll be cared for by the
dedicated staff sensitive to their needs, will
change our community dramatically.

Let me just describe a little bit about what
it's like for a mental health patient in community
hospitals today on many occasions.

There's a great need for mental health
services. Patients typically arrive to our door in
their worst hour of need. They've run out of
resources, they burned bridges with family, with
friends, and within their community, and they come
to us in their hour of need. And they have nowhere
to go, so they come to the emergency department.

Many times they don't have access to
psychiatric care or to their medications. They may
not have the funds for the medications or be on the
correct medications and their diseases are out of
control.

These patients, unfortunately, may spend
anywhere from 6 to 48 hours in the emergency
department awaiting placement for appropriate facilities because, as you're aware, mental health services in the state of Illinois have been decreased over the last decade or so with closures of our State-supported hospitals. Hopefully, we'll be able to fill that void with Silver Oaks.

So what happens in the emergency department? Unfortunately, the patients may spend a day and a half or two days waiting for placement, and, hopefully, Silver Oaks will be able to alleviate that concern.

We do our best to care for those patients while they're in the emergency department. We provide sitters, social services, and our technicians who are trained to deal with their issues as well as the emergency physicians and nurses; however, this isn't the ideal situation, as you can imagine.

US HealthVest will accept ambulances, they'll accept patients, as mentioned, with no consideration for what their insurance status is, and we'll have a continuum of care between the emergency department at Silver Cross and the Silver Oaks Hospital. Our goal is to keep the
patients in the community and provide them with the appropriate care, and I'm certain that the care provided at the Silver Oaks Hospital with US HealthVest will deliver on that promise.

So as an emergency physician and a member of the community, I urge you to accept and approve this proposal.

Thank you.

CHAIRWOMAN OLSON: Thank you, Doctor.

MS. COLBY: We'd be happy to answer any questions.

CHAIRWOMAN OLSON: Sure.

Questions?

Mr. Sewell.

VICE CHAIRMAN SEWELL: Yes.

I want to skip over to the 1120 criteria on the financial viability.

There's a finding here that you don't meet that, and it looks like -- I don't need for you to unpack the distinction between Silver Oaks Hospital and Silver Oaks Realty, but it looks like there's two issues here.

One is you don't have historical financial instruments, and the other is you don't meet the net
margin ratio. So could you explain to us what that is -- what that ratio is and what the significance of not making it is for the financial viability of your hospital?

MR. CHA: With regard to those two entities, Silver Oaks Behavioral and Silver Oaks Behavioral Realty, both are new entities created for the purpose of establishing this hospital, and, as such, they don't have historical financial information.

And as it relates to the net margin requirement -- so that would require the entity itself to be profitable, and there was a question that was raised -- a legitimate finding in the staff report -- that Silver Oaks Behavioral Realty does not meet that requirement. And the reason for that, the realty company and Silver Oaks Behavioral should actually be considered on a combined basis because the realty company -- its only function is to manage the real estate, to own and lease the property.

So, in fact, the revenue that is generated by the realty company is a somewhat arbitrary number because that rent is paid by the hospital to the realty company, and it gets eliminated upon consolidation because the revenue for the realty
company is canceled out by the rent that's paid by
the hospital.

So we could -- since -- it could be the case
that we could increase the rent, which would just be
an intercompany rent paid between the two entities,
and, thereby, the realty company would meet that net
margin criteria.

VICE CHAIRMAN SEWELL: So am I overreaching
to say that you don't satisfy this particular ratio
because you don't have historical financial
statements? Or is it that those two entities need
to be treated as combined? And that's what you just
said, with internal transactions with respect to
rent.

MR. CHA: Yes. It's my understanding that
it's the latter.

THE COURT REPORTER: Could you state your
name for me, please.

MR. CHA: My name is James Cha. I'm the CFO
of US HealthVest.

THE COURT REPORTER: Thank you.

VICE CHAIRMAN SEWELL: So would -- Mike, do
you agree with that?

MR. CONSTANTINO: Yeah. We can't combine
them because we look at the Applicants and co-Applicants.

VICE CHAIRMAN SEWELL: Okay.
All right. I'm done.
CHAIRWOMAN OLSON: Other questions?
(No response.)
CHAIRWOMAN OLSON: I just want to clarify something.
I think -- did I hear you correctly? Did you say there's 75 AMI beds in this planning area for 70,000 residents?
MS. COLBY: 700,000. There's more than 700,000 residents.
CHAIRWOMAN OLSON: And only 75 AMI beds?
MS. COLBY: That's correct.
CHAIRWOMAN OLSON: Okay. And I think I read, also, in the application that you're anticipating 27 percent Medicare and 37 percent Medicaid.
MS. COLBY: That is correct.
CHAIRWOMAN OLSON: Thank you.
I don't have any other questions.
Doctor.
MEMBER GOYAL: Thank you, Madam Chair.
My name is Arvind Goyal. I represent Medicaid and I have two questions for you.

The Medicaid part of your population as projected, would you be able to save those beds for Medicaid?

Because we run into a situation where entities or patients need to be admitted to an AMI bed and, when somebody contacts them, then they're told, "Well, we don't have any beds available." At the same time they may be able to admit commercial insured patients and not Medicaid.

So what kind of commitment are you able to give under oath at this time?

DR. KRESCH: Our policy, as enacted on a daily basis at Chicago Behavioral Hospital, is we admit every patient that comes to the hospital if they meet admission criteria as they come, regardless of ability to pay or whether they have -- type of insurance. Whether it's Medicaid, Medicare, managed care, or no insurance, each patient is treated as they come.

So we will admit any patients that that happens. So the -- using the model of Chicago Behavioral Hospital, the bulk of our patients are
Medicaid patients. Many of them are managed Medicaid patients but, ultimately, still Medicaid patients.

We treat patients as patients. We treat, really, anyone who comes to the hospital without regard to pay. Our experience at Chicago Behavioral Hospital is that the hospital is full and we frequently have to divert patients because there are no available beds that will fit the need of a particular patient. It could be a male; we only have female beds or something like that.

So we do take every patient, and it would not be needed to save beds because we don't discriminate between Medicaid and other payers.

MEMBER GOYAL: Thank you very much.

And my second question is, if you were to admit a substance abuse disorder patient, which may be a part of your specialty hospital, if you will, then would you always ensure a continued outpatient follow-up? Or is it "We've treated you, not much we can do, go see somebody else" and "Here's a list"?

DR. KRESCH: No patient leaves the hospital without a follow-up appointment within -- preferably within a few days at the most.
They're accompanied by a family member or a representative if they're living in an institutional setting. And a fail-safe, sort of worst-case scenario, the hospital itself has a day hospital program, an IOP and PHP. And if we have difficulty finding a good disposition, proper disposition for the patient, we'll take care of that patient ourselves.

MEMBER GOYAL: Thank you very much.

CHAIRWOMAN OLSON: Joel and then -- either one. Go ahead.

Ladies first.

MEMBER MURPHY: I have a question about 730(d)(1), the unnecessary duplication of services. And -- I don't know. Maybe it's just a numbers thing and I'm not getting it.

But your testimony seems to say that there's just really this need; however, our report says there's only a calculated need for 16 beds. If there are currently 75, there's a need for 16, you're proposing a hundred, but you're going to discontinue 20, so it's basically an 80-bed gain.

So where's the difference between the 16 and 80? Your numbers make it sound -- I mean, when you
said 75 for 750,000 people, how did -- is this
another one of those standards that we don't know
where it came from but supposedly we only need 16?

MR. CONSTANTINO: No. There's 75 AMI beds
right now.

MEMBER MURPHY: Right.

MR. CONSTANTINO: They've got 20 AMI beds in
operation at the Silver Cross Hospital. Once this
project is finished, that will be deleted. They'll
be discontinued --

MEMBER MURPHY: Right.

MR. CONSTANTINO: -- those 20 beds. That's
where those 20 beds come from.

MEMBER MURPHY: Right. But then --

MR. CONSTANTINO: And they're proposing --

MEMBER MURPHY: So your standard that's not
met says you only need 16, but you're proposing a
hundred.

That's --

MR. CONSTANTINO: Okay. If you take -- if
you look at it like that, there would be the 16 and
20 that they're going to discontinue or the 36 --

MEMBER MURPHY: Right.

MR. CONSTANTINO: -- beds available.
MEMBER MURPHY: Right.

MR. CONSTANTINO: Okay. So they're essentially adding the difference between the hundred they're requesting and the 36 that would be available.

CHAIRWOMAN OLSON: I think what she's saying is, if there's only 75 AMI beds for 700,000 residents, how can there be not a 700-bed need or something? I guess is what we're trying to get at. Right?

MEMBER MURPHY: Right.

Why does it mean they did not meet this criteria? Because you say there's a calculated need for 16 beds, and you're proposing a hundred.

And I would seem to think that it would be better, considering the issues and the population, so -- your justification for a hundred beds --

MS. COLBY: Excuse me. I think -- I'll ask Mike to talk about the State standards, but, as we all know, this crisis in mental health is growing extremely rapidly, especially as it pertains to opiates and drug abuse and people not finding a place to go.

MEMBER MURPHY: Right.

MS. COLBY: So what we did was we reached
out to all the agencies in the area and the fire
departments and the police and the courts. And we
said, "What are you seeing? Where -- how many
people do you believe need an AMI bed?" And that's
where all these referral letters came, where we were
able to justify -- I think the State has accepted --
what was it, Mike? 2400 or something? -- of the
referrals --

    MEMBER MURPHY: Right.

    MS. COLBY: -- which is well beyond the need
for 16 beds.

    MEMBER MURPHY: Right.

    MS. COLBY: And then it depends on the
length of stay. We used a very conservative length
of stay.

    Chicago Behavioral Health Department --
    Chicago Behavioral Hospital has shown that, with a
longer length of stay, there's less recidivism. So
if we look at that, we can justify the hundred beds
real easy. Because it's really based on the
community needs and the letters that have come
forward.

    MEMBER MURPHY: I mean -- I agree with you.

So it's basically numbers versus reality?
MS. COLBY: Yes.

CHAIRWOMAN OLSON: Joel.

MEMBER JOHNSON: You touched on what I was going to ask.

What is your anticipated length of stay or what --

MS. COLBY: Yes.

MEMBER JOHNSON: -- is Chicago Behavioral's length of stay --

MS. COLBY: Yes. So -- oh, I'm sorry.

MEMBER JOHNSON: And then, while you answer that, I guess the other thing is, what percentage of these 100 beds do you anticipate being crisis oriented? Or will that shift based on need?

MS. COLBY: I'll let you answer the crisis part.

But I can tell you the length of stay at Silver Cross has been 6.4 in our psychiatric unit and Chicago Behavioral is 9.6.

DR. KRESCH: So, essentially, all of our patients are in crisis when they're admitted. The admission criteria for psychiatric hospital inpatient service is that a patient has to be a danger to themselves, others, or so disorganized
that they can't take care of themselves.

So all of our patients come in in an acute state of disorganization or a threat, generally, to someone. Depression is our most common admitting diagnosis, and suicidal behavior or ideation is a key indicator for admission.

The length of stay at Chicago Behavioral Hospital is a little bit more than Silver Cross. Chicago Behavioral sees a very high-acuity patient population. In fact, the patient population there is so high -- the acuity is so high -- that we have different levels of intensive care units. So as a patient is stabilized, we're able to move them along to greater independence.

But the length of stay will -- typically, on a national basis, length of stay averages about eight to nine days.

MEMBER JOHNSON: So, then, what's the utilization of Silver Cross' 20 beds? What's the average census?

MS. COLBY: In the State report it was at 80 percent occupancy. We have been -- we have many days here that we're full, all 20 beds are full. And sometimes we'll be at 15, 16, somewhere
around there because, as described before, there could be gender match issues, or somebody who is extremely psychotic can't be placed with somebody who is a young teenager who may have some other types of issues.

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

MS. COLBY: Oh, 85 percent this year.

I'm sorry.

CHAIRWOMAN OLSON: Mr. Sewell.

VICE CHAIRMAN SEWELL: Yes.

I'm having a little trouble understanding this finding on page 3 of the State agency report about unnecessary duplication of services.

These facilities, they are not AMI facilities? They're just hospitals?

MR. CONSTANTINO: They have AMI units.

VICE CHAIRMAN SEWELL: Yeah. Within that?

MR. CONSTANTINO: Yeah.

VICE CHAIRMAN SEWELL: Okay. That's a little misleading, you know, because it makes it look -- so the 53 percent occupancy is overall for those facilities?

MR. CONSTANTINO: That's correct, yeah.

VICE CHAIRMAN SEWELL: Okay. I'm going to
disregard that one.

(Laughter.)

CHAIRWOMAN OLSON: You're entitled, sir.

MR. CONSTANTINO: Now, our bed need formula includes those beds --

VICE CHAIRMAN SEWELL: I know. That's in the other one, though.

MR. CONSTANTINO: Yeah. That bed need formula includes these beds, yeah.

VICE CHAIRMAN SEWELL: Okay. Yeah.

CHAIRWOMAN OLSON: Any other questions or comments?

(No response.)

CHAIRWOMAN OLSON: I'd ask for a roll call vote, please.

MR. ROATE: Thank you, Madam Chair.

Motion made by Senator Burzynski; seconded by Mr. Sewell.

Senator Burzynski.

MEMBER BURZYNSKI: I'm going to vote yes based on the testimony we've heard today and the need and the support from the community.

MR. ROATE: Thank you.

Senator Demuzio.
MEMBER DEMUZIO: I'm going to go ahead and vote yes based upon the testimony that I've heard.

MR. ROATE: Thank you.

Mr. Johnson.

MEMBER JOHNSON: I'm also going to vote yes based on the testimony.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: I'm voting yes based on the testimony.

MR. ROATE: Thank you.

Ms. Murphy.

MEMBER MURPHY: Yes, based on today's testimony.

MR. ROATE: Thank you.

Mr. Sewell.

VICE CHAIRMAN SEWELL: I'm going to vote no based on projected utilization and planning area need.

MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: I'm going to vote yes based on the testimony and the fact that there was no opposition despite the findings.
MR. ROATE: That's 6 votes in the affirmative, 1 in the negative.

CHAIRWOMAN OLSON: The motion passes.

Congratulations.

MS. COLBY: Thank you. Thank you very much.

MS. SZE: Thank you very much.

CHAIRWOMAN OLSON: Good luck.

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CHAIRWOMAN OLSON: Next, I'll call H-04, Project 17-010, Mercy Circle.

May I have a motion to approve Project 17-010, Mercy Circle, to remove a CCRC variance.

MEMBER DEMUZIO: Motion.

MEMBER JOHNSON: Second.

CHAIRWOMAN OLSON: And will you please swear in the Applicant.

THE COURT REPORTER: Would you raise your right hands, please.

(Three witnesses sworn.)

THE COURT REPORTER: Thank you.

CHAIRWOMAN OLSON: Mr. Constantino, your report.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The Applicants are requesting the Board to remove a CCRC variance and a defined population variance that was part of Permit No. 11-008, Mercy Circle. At that time the Board approved a 23-bed long-term care facility.

The anticipated project completion date is December 30th, 2017. There is no cost to this project. There was no opposition, no public hearing. And we did have one finding, an
unnecessary duplication of service on page 3.

Thank you, Madam Chairwoman.

CHAIRWOMAN OLSON: Thank you, Michael.

Comments for the Board, please.

MS. LACHOWICZ: Good afternoon. Thank you for your time today. I know it's late so we'll be very brief.

My name is Frances Lachowicz. I'm the executive director at Mercy Circle. To my right is Billie Paige and Ira Rogal. They are our CON consultants.

We're asking that the lifting of the restrictions -- or stipulations be removed. Madam Chairwoman and members of the Board, Mercy Circle is a continuing care retirement community in Evergreen Park on the southwest side of Chicago.

Our application is before you today because the number of men and women religious is declining and is going to continue to decline. Mercy Circle is the only faith-based continuing care retirement community in our area, and it does not require an entrance fee or a buy-in. Many of the family members living in the area are interested in sending their loved ones or themselves into a faith-based
long-term -- continuing care retirement community.

A response to the negative in the report is that this is only 23 beds. The planning area does have 4500 beds. We are just asking that these stipulations be lifted and that they wouldn't have much impact on our other facilities in the area.

We appreciate your kind consideration today.

CHAIRWOMAN OLSON: Thank you.

Questions?

Richard.

VICE CHAIRMAN SEWELL: Okay. Everybody else here understands this except me.

I'm not getting the connection between the action we're supposed to be taking of removing these variances and this finding about the excess beds in the planning area.

MR. CONSTANTINO: The variances were put in place because they were only going to serve the religious order when this facility was originally built. That was part of the long-term care rules, the variance to calculated need.

VICE CHAIRMAN SEWELL: Yeah.

MR. CONSTANTINO: They've come to find out they need -- they don't need that variance. They
need to make these beds available to the entire community.

So that is the reason why we have the finding, because now they're going to be competing with the others in the community, other nursing homes in the community.

VICE CHAIRMAN SEWELL: But if we remove this variance, what if -- I mean, I don't get the so-what question. I mean --

MR. CONSTANTINO: The variance -- they can only -- right now, they can only accept nuns from this religious order.

VICE CHAIRMAN SEWELL: Oh.

MR. MORADO: The CCRC variance creates a closed community, so it kind of feeds within itself. And what they want to do is take that away so they can open the doors.

VICE CHAIRMAN SEWELL: I get that. But why does it matter if there's an excess of beds in the planning area?

MR. CONSTANTINO: Because we're adding more beds to that area.

VICE CHAIRMAN SEWELL: Oh, the beds that they have?
MR. CONSTANTINO: Yeah.
VICE CHAIRMAN SEWELL: Okay. Thank you.
Everybody -- just bear with me. Everybody else got that, just not me.
CHAIRWOMAN OLSON: Is the light on? The light came on.
Other questions?
(No response.)
CHAIRWOMAN OLSON: Seeing none, I'd ask for a roll call vote.
MR. ROATE: Thank you, Madam Chair.
Motion made by Senator Demuzio; seconded by Mr. Johnson.
Senator Burzynski.
MEMBER BURZYNSKI: I vote yes based on my understanding of the explanation.
MR. ROATE: Thank you.
Senator Demuzio.
MEMBER DEMUZIO: Yes, based on whatever -- what you said before.
(Laughter.)
MR. ROATE: Thank you.
Mr. Johnson.
MEMBER JOHNSON: Yes, based on the
explanation provided by the testimony.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on reasons previously stated.

MR. ROATE: Thank you.

Ms. Murphy.

MEMBER MURPHY: Yes, based on today's testimony.

MR. ROATE: Thank you.

Mr. Sewell.

VICE CHAIRMAN SEWELL: I'm going to vote yes and blame it on the Kentucky public school system.

(Laughter.)

MEMBER DEMUZIO: What?

MR. ROATE: Thank you.

MR. MORADO: That's the public school system we're just so impressed with. One more reason?

VICE CHAIRMAN SEWELL: No, the reason is that I understand it and I think it's appropriate --

MR. MORADO: Thank you.

VICE CHAIRMAN SEWELL: -- what they're doing.

MR. ROATE: Madam Chair -- thank you.
Madam Chair.

CHAIRWOMAN OLSON: Yes, based on the reasons stated by Mr. Sewell, the second one.

MR. ROATE: That's 7 votes in the affirmative.

CHAIRWOMAN OLSON: The motion passes.

Congratulations.

MS. LACHOWICZ: Thank you so much. We appreciate it.

(Applause.)
CHAIRWOMAN OLSON: Okay. Next, I'll call Project 17-011, Carle-Staley Road medical office building. And I will mention there are no opposition and no findings to this project.

May I have a motion to approve Project 17-011 --

MEMBER JOHNSON: So moved.

CHAIRWOMAN OLSON: -- Carle-Staley Road medical office building.

Okay. Great.

And this is in Champaign.

We have a motion. And a second?

MEMBER DEMUZIO: Second.

CHAIRWOMAN OLSON: Mr. Constantino.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The Applicants are proposing to establish a medical office building in Champaign, Illinois, at a cost of about $66.8 million. The project completion date is August 31st, 2019.

No opposition, no public hearing, and no findings.

Thank you.

CHAIRWOMAN OLSON: Thank you, Michael.

MS. COOPER: Hello. I'm Anne Cooper --
THE COURT REPORTER: Hold on.

CHAIRWOMAN OLSON: Hold on. Before you begin -- I'm sorry. We're getting way ahead of ourselves.

(Three witnesses sworn.)

THE COURT REPORTER: Thank you.

CHAIRWOMAN OLSON: Anne.

MS. COOPER: I'm Anne Cooper from Polsinelli. I'm counsel to Carle.

To my right -- or left -- is Collin Anderson and Nick -- sorry -- Crompton.

Given the fact that this project has no findings, no opposition, we would like to defer providing any comments on this project, and we'd be happy to answer any questions.

CHAIRWOMAN OLSON: Thank you, Anne.

I appreciate that.

Are there questions or comments regarding this?

(No response.)

CHAIRWOMAN OLSON: Okay. I'll take a roll call vote.

MR. ROATE: Thank you, Madam Chair.

Motion made by Mr. Johnson; seconded by
Senator Burzynski.

MEMBER BURZYNSKI: Yes. There were no staff findings and -- negative findings -- and no opposition.

MR. ROATE: Thank you.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the -- on a very good application.

MR. ROATE: Thank you.

Mr. Johnson.

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

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on the State agency report.

MR. ROATE: Thank you.

Ms. Murphy.

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

MR. ROATE: Thank you.

Mr. Sewell.

VICE CHAIRMAN SEWELL: Yes. No findings.
MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: Yes. No findings.

MR. ROATE: That's 7 votes in the affirmative.

CHAIRWOMAN OLSON: Thank you.

And thank you for staying all day --

MS. COOPER: Thank you.

CHAIRWOMAN OLSON: -- for that five minutes.

- - -
CHAIRWOMAN OLSON: Next, Project 16-058, Dialysis Center of McHenry.

May I have a motion to approve 16-058, Dialysis Center of McHenry, to establish a 14-station end stage renal dialysis facility in McHenry.

MEMBER DEMUZIO: So moved.

CHAIRWOMAN OLSON: May I have a second, please.

MEMBER MURPHY: Second.

CHAIRWOMAN OLSON: The Applicant will be sworn in, please.

THE COURT REPORTER: Would you raise your right hands, please.

(Five witnesses sworn.)

THE COURT REPORTER: Thank you.

CHAIRWOMAN OLSON: Mr. Constantino, your report.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The Applicants are proposing to establish a 14-station in-center hemodialysis facility to be located in McHenry, Illinois, at a cost of approximately $1.2 million and a completion date of March 31st, 2018.
There was no public hearing. There were letters of support and opposition received for this project, and we did have State Board findings.

Thank you, Madam Chairwoman.

CHAIRWOMAN OLSON: Thank you.

Comments for the Board? Please introduce yourselves, please.

DR. SALAKO: Sure. Good afternoon, Madam Chair and members of the Board.

I am Dr. Babajide Salako. I am the CEO of Dialysis Care Centers. To my right is Dr. Farhan Bangash, who is the medical director of our clinic.

To my left is Mr. Asim Shazzad, who is my chief operating officer. To his left is Ms. Melissa Smith, who is my area manager. And to her left is Ms. Kristin Paoletti, who is my director of clinical operations and chief nursing officer.

Thank you for giving us the opportunity to speak on this project. I know it's been a very long day. I will say that we appreciate the opportunity to present our case to the CON Board.

Despite the findings of the State agency report in opposition, we want to categorically say that we in the McHenry market -- we are interested
in this. This project is of particular interest to us because of what we believe we are going to bring to the market.

Dr. Bangash's practice is heavily focused on home dialysis, and in the last few years what we have discovered is that several of our patients, when they have gone into the in-centers, to some of our competitors -- ARA, Fresenius, DaVita -- several of those patients have been talked out of home therapies. Those patients have remained to stay on in-center dialysis.

It's well known in the community of ESRD patients that patients do much better on home therapies, either peritoneal dialysis or home hemodialysis, and transplant rates are also high in those patients. Those patients tend to work longer and are less of a burden onto society.

One of the reasons why we want to pursue this project is there's a continuum of care philosophy that we have that, when our patients do go into in-center, they will be there for a transient period of time and, when there's a need for them to go back and do peritoneal or any kind of home dialysis, it will be a very seamless
transition.

We also believe that this project is extremely important because it allows this -- since this dialysis company is physician owned and physician managed, there's a strong emphasis on quality. We're not bean counters, whereby we are always looking at the bottom line with appropriate treatment and types of policies and procedures that are not in the interests of the patients.

We've been very successful in this model in other clinics outside the state of Illinois, and we would like to bring that same standard of care and practice to the Illinois dialysis environment.

I would like Dr. Bangash, the medical director, to say a few words.

CHAIRWOMAN OLSON: Thank you.

DR. BANGASH: Thank you, Dr. Salako. And thanks for letting us have the opportunity to speak.

My name is Farhan Bangash. I'm a board-certified nephrologist in McHenry County for the past five years.

I'm here to support Dialysis Care Center, which is a physician-owned, physician-managed dialysis unit that would provide care to dialysis
patients in McHenry County.

With a physician-owned and physician-run model, this dialysis unit would put patients first and not treat patients like a one-size-fits-all model that, unfortunately, is seen in other dialysis units in the area.

I'll give a little background about my practice. When I started the practice five years ago, I started from scratch, and at that time everyone said, "You must be crazy. There's too many nephrology groups in the area, not enough patients," just, basically, "Don't do it."

I'm from the area, decided to pursue the practice anyways, and now, five years later, the practice has done well. We have three physicians, one nurse-practitioner, multiple employees, multiple offices, and we're looking to grow.

What kind of shocked me when I first started the practice was the lack of knowledge that our patients knew about dialysis. It seemed like every dialysis patient I had met only knew about in-center hemodialysis, and this included young individuals with families who are working. They had not even heard that transplant or even home dialysis was an
option. So they were going to the center for four
to six hours three times a week and had to, you
know, quit their jobs and just stay on in-center
hemodialysis.

I trained with one of the renowned
physicians during my fellowship in home dialysis,
Dr. Fufoxer [phonetic], and I've just always been a
firm believer in home dialysis. So when I saw that
the patients in McHenry County did not have the
right, really, education about home dialysis, that's
when I really wanted to pursue my own home dialysis
program. So five years later here, we have now the
largest home dialysis population in McHenry County.

Just a little background: The United States
is the only country that uses in-center hemodialysis
more than home dialysis, and we know that it costs
a significant amount more to run in-center
hemodialysis units.

Unfortunately, you would think, "Okay.
Maybe, if the outcomes are better, then we should
keep doing that." We actually have worse outcomes.
So we're spending more with worse outcomes.

So, you know -- the other thing, I guess,
that I want to go over, these patients that are home
dialysis patients, they almost become like family to us. We see them multiple times a month, once a month when we do our interdisciplinary rounding with them. It's me, the dialysis nurse, social worker, dietician. We're all sitting around a table. We go over all of these aspects in one sitting.

I have most of my patients' cell phone numbers. They have my cell phone numbers. Our nurses have their cell phone numbers. They're communicating at all times with any issues, and they do great, really, on home dialysis.

Now, the issue that I have seen is, unfortunately, the home dialysis patients cannot be on home dialysis forever. This is -- it's usually a bridging to transplantation or, for a variety of medical reasons, they then eventually need to go onto hemodialysis, and this is where I really saw the problem and where this project kind of started from.

When our patients in the home program were going to the in-center hemodialysis units in the area, even if it was just for a couple weeks and to buy them some time until they get back at home, they automatically went into the algorithm that these
major companies -- ARA, DaVita, Fresenius -- have
where it's -- honestly, it's all about the bottom
line.

So these patients would go in there, they'd
get multiple testing done, they'd be told that they
can't go back to home dialysis, they'd be sent for
unnecessary procedures, told that they needed a
fistula and that home dialysis was done for them.

On multiple occasions I had to stop this
process. Unfortunately, some testing had already
been done. Me, not being a medical director at any
of these dialysis units, I cannot make any changes
to how they run their units, and that is what I have
to deal with.

So, really, what this dialysis center
project would do for my home dialysis patients in
particular and future dialysis patients is it would
take the one-size-fits-all model away and we would
treat each dialysis patient as an individual.

We know that men dialyze differently than
women. Elderly dialyze differently than younger
individuals. Patients with higher body mass dialyze
differently than patients with lower body mass.

But in -- unfortunately, with ARA,
Fresenius, DaVita, it's all the same. It's just an algorithm. You go in, do dialysis, and everyone is the same.

This dialysis unit would serve to change that. We would treat each patient as an individual. We would keep continuity of care from my home dialysis population who eventually would need to go into the in-center. They would be dealing with the same nurses, same physicians, and, really, kind of keep the same quality of care that they'd been receiving.

DR. SALAKO: Before I pass it over to my clinical team to say one or two things, I want to talk about the State agency report. There's an issue there about no backup agreement.

Those agreements where they're part of Centegra-McHenry, it takes a while. It has to go through their legal processes, their lawyers, their internal systems. But a transfer agreement, usually a standard practice, you wouldn't get certified -- get a CMS certification -- if you don't have one, and we don't anticipate any problems with that.

In terms of utilization, from our perspective, what we've always looked at is, if you
look at the McHenry community there with over
50,000 patients, it continues to grow. At the
moment that community has upward of about
250 dialysis patients; again, it grows about
5 percent.

That means that, if you combine a plan
group, 5 percent ESRD relationship which is
nationwide, and you look at the decrease in
mortality of patients on dialysis, patients that
stay longer on dialysis, you're going to see that,
in the next five years, you're going to double the
number of patients you have on dialysis in McHenry
County.

So utilization, I think, is something
that's -- it's -- there's a lot there, but it's
within -- you don't want an institution in which the
lag -- where the legitimate time it takes to build
the clinic and the need -- there's a significant lag
of 18 to 24 months. So you want to keep abreast of
what's there.

Another thing that's also very important is
most of these patients don't have a choice. If you
want an institution in which, if you're a patient,
you can say, "Hey, I want to dialyze Monday,
Wednesday, Friday, first shift, second shift, third shift" -- or Tuesday, Thursday, Saturday, first shift, second shift, third shift -- you don't want a situation in which, once you start to dialyze, you're forced into a certain shift.

What tends to happen with that is, if the person is working, they will usually lose their job because it's very few employers that will say, "Oh, Mr. Jones, Dr. Salako, you can't come to work -- you can't come to work at a certain time three days -- three times a week." So you need the flexibility there.

And you also -- going back to what we said, from our point of view, the focus on also using this as a tool to actually get our patients home and to keep our patients at home is a big factor in doing this project.

I'll hand over to Ms. Melissa Smith and to say a few words.

MS. SMITH: Okay. Thank you for your time.

I'm just going to look at it from a patient care standpoint. I have trained the majority of the home program patients in our clinic.

I started with -- when Dr. Bangash began his
practice, about two years into it. We've grown the program tremendously, and his comments on how attached the patients become to their care team are huge in dialysis.

If you have any family members or friends that are using dialysis currently, you know that it becomes a huge part of their life. It's something that they don't get to ever stop doing unless they get a transplant or pass away.

So when they are connected to their care team, it's traumatic for them -- let's say if they can't be a home patient anymore. And now not only can they not be on their home therapy anymore, but they can't even be involved in your program anymore because you don't have the option to send them to an in-center facility that is run under the same standards and quality care that they provide for them currently.

So this would just give them an opportunity to -- even though we're giving them other traumatic news, that they can no longer stay on the home program, but it's okay because your care team is going to go with you to where we're transitioning you.
MS. PAOLETTI: Hello and thank you for your time.

Basically, everybody covered everything that I was going to say -- basically, everybody covered everything that I was going to say.

My main thing is think of the patients when you're considering your decision. It's super important.

Thank you.

CHAIRWOMAN OLSON: Thank you.

Mr. Sewell, a question?

VICE CHAIRMAN SEWELL: Is this application before us too soon? Shouldn't you have gotten the written agreements for inpatient and other hospital services before? Because if we approve this, you could actually get started before you had it.

MR. SHAZZAD: I would say -- I would refer this to Mike Constantino to comment on this question. Me and him had this discussion about this.

MR. CONSTANTINO: Yeah. They can't operate this facility without that agreement.

VICE CHAIRMAN SEWELL: Okay.

MR. SHAZZAD: So we wouldn't.
VICE CHAIRMAN SEWELL: The other thing -- I'm okay with that.

The other thing is, is it correct to say that you're asking us to approve this in spite of these findings because you're doing home dialysis?

DR. SALAKO: No. What we're asking you to say, we're -- we are trying to highlight a new environment in which dialysis care is being provided. Okay?

And we're looking at a group of patients. We're saying, "Hey, this is what's commonplace at the moment. If you" -- Fresenius or DaVita own 90 percent of the clinics here in Illinois. All right? ARA owns three. But they're big deals. They own the terrain.

They do not have -- they have less than 10 percent of their patients dialyzing at home. Okay? Dr. Bangash has close to 60 patients dialyzing at home. Different -- you know, different thing completely. All right?

So we're telling you that what we've noticed is that, if you are a home patient now and you say, for instance, had a bout of peritonitis -- okay? -- and you needed to have your PD catheter removed --
and you said, "Okay; fine" -- you need to have home
therapy for -- in-center dialysis for four weeks
before your PD duct is replaced. Or if you are a
home hemo patient, your caregiver is your wife.
Your wife needs to go on vacation -- she's tired --
and you want to go into an in-center for two weeks
while your wife goes on vacation.

We're telling you that what's happening now
is, when the patient gets to that in-center, that
patient is going to become a cookie-cutter
in-patient, and they're going to tell the patient,
"Oh, come in here, become dependent, become
dependent on nursing care, become dependent on
coming in." And we can tell you -- there's a lot of
data to support it -- that that patient's outlook is
a whole lot less.

If we have -- Dr. Bangash becomes medical
director and comes back with this program, he knows
his patients. His practice is growing. He has
three physicians; two more are coming in to join him
next year.

Those physicians will know that Mr. Jones is
coming in, he's going to get dialysis for four
weeks, he's going to get his PD catheter, he's going
to go back home. Mr. Jones' wife is going to come back from vacation, he's going to continue his home hemodialysis.

We are going to continue to focus on home even with our in-center. It's going to become a tool in our toolbox in providing dialysis care for our patients, not just a single line of therapy, which is what you're getting with Fresenius or DaVita or ARA.

We're just trying to change the paradigm and how everybody thinks about dialysis care, about how they should manage patients. That's all we're asking.

VICE CHAIRMAN SEWELL: Now, does the literature talk about roughly what proportion of dialysis patients meet the criteria for home dialysis?

In general. Not what DaVita and Fresenius have. But is there any research on that?

DR. SALAKO: I can -- in the United States, about 10 percent of our patients are on home therapies. In Mexico, next door, 75 percent. Okay? In Hong Kong it's over 90 percent. Okay?

So the focus is driven by the physician and
the providers. If I'm at Fresenius or DaVita,
I have these big boxes, I build 200 clinics a year,
I need to fill those clinics. I'm going to push
those patients to come to work -- to the in-center.
What happens is they lose their freedom; they lose
convenience; most of them stop working. It's
expensive. They're a bigger burden on the tax
system.

DR. BANGASH: I will also add to that
there's very relative -- there's only a few
contraindications to not doing dialysis at home.

It is -- it's tougher for the physicians to
start it. It's more work for us. You have to
really keep an eye on them. It's easier to just put
them in the center. You just say, "Okay" -- you
know, put a catheter in, "Go to the center three
times a week." It's all in the algorithm, "Do this,
do that."

In home dialysis you have to take more time
with them. You have to know the patients, get to
know them. You have to individualize the
prescription for them.

But we have people in their 90s, their early
90s, that are dialyzing at home.
CHAIRWOMAN OLSON: Joel.

MEMBER JOHNSON: So to the State finding around projected utilization, I think you just said that you have an estimate of 60 home dialysis patients.

DR. BANGASH: I think you -- it was a total of 60 dialysis patients, and then 38 are in our home program.

MEMBER JOHNSON: So 38 in your home program. And the projected -- or historical referrals of 53 patients, does that include those home dialysis patients?

MR. SHAZZAD: I was going to say the State does not count home dialysis patients into their number.

DR. BANGASH: They were just looking at our Stage III, Stage IV kidney disease patients, so they were not looking at those 38 patients.

MEMBER JOHNSON: That's the point I was trying to get at. So these are not including those 38 patients.

And so what you're asking us to do is to consider the fact that in -- for this proposal -- that at a point in time in your model of treatment
the home dialysis patients will need in-center care, and you'd like to allow them the opportunity to transition back to home dialysis care as opposed to being stuck in the scenario where they're bound to --

DR. SALAKO: Absolutely, absolutely.

MR. SHAZZAD: Correct.

CHAIRWOMAN OLSON: Doctor.

MEMBER GOYAL: Two questions from me: One, could you give us a price differential from a consumer or insurance point of view of -- for home versus hemodialysis?

DR. SALAKO: Well, you know, in terms of reimbursement, Medicare pays essentially the same rate. What happens is hospitalization in patients at home is a whole lot less.

So if you're American patient and you are getting paid -- the providers are getting paid X amount of money, the burden on Medicare, on the Medicaid, any other State provider is much higher because these patients typically are spending about 14.4 days a year in hospital as against your home patients, who are spending somewhere between 3.5 to 5.5 days a year in hospitals.
So the burden really -- because of better outcomes and reduced hospitalizations, that's where it's less expensive on the payer.

MEMBER GOYAL: You didn't answer my question yet.

Is there a price differential between home dialysis cost versus hemodialysis? You can answer it for commercial or for any plan or generally.

DR. SALAKO: Payer or cost?

Payer or cost? In terms of how they pay --

MEMBER GOYAL: Cost. Just a general differential in terms of, "Hey, home costs a dollar and hemodialysis in a center costs a dollar and a half."

DR. SALAKO: It's cheaper to dialyze at home.

MEMBER GOYAL: How much cheaper?

DR. SALAKO: I couldn't tell you off the top of my head right now.

MEMBER GOYAL: Any fractions any of you have?

DR. SALAKO: I tell you about -- it's about .75 to .8 of an in-center cost.

MEMBER GOYAL: Okay. My final question
is -- you are basically asking the Board to look at your plan as encouraging and promoting home dialysis over hemodialysis.

DR. SALAKO: At hemodialysis in-center, yes.

MEMBER GOYAL: I understand that.

So how would the Board on your approval -- if you are granted that, how would we be able to monitor that you're really doing this after this period?

DR. SALAKO: I think, you know, the easiest way is over the -- the local network here can always communicate with the Board a year or two years or three years into this and come back and say, "Hey, look at this particular clinic. How are they doing? What is the percentage of that? What are they reporting to the ESRD network as a percentage of their patients that are home?"

And once you can see that variance, I'll be happy to bring back data to say -- a year from now, 18 months again, two or three years from now -- "This is the percentage of our patients at home," you know, two or three times the national average. In our clinics outside the state of Illinois, that's what we're experiencing thus far, so we're very
confident that we can repeat that in the state of Illinois.

MEMBER GOYAL: Thank you.

CHAIRWOMAN OLSON: Other questions?

MEMBER BURZYNSKI: Just a follow-up real quick?

CHAIRWOMAN OLSON: Yes.

MEMBER BURZYNSKI: Thank you.

Just a follow-up for Mike, clarification for me.

So if we approve this today, they still cannot move forward until they receive the --

CHAIRWOMAN OLSON: Affiliation agreement.

MEMBER BURZYNSKI: Yeah, the affiliation, the --

MR. CONSTANTINO: Yeah.

MEMBER BURZYNSKI: Yeah. Okay.

CHAIRWOMAN OLSON: Other questions or comments?

(No response.)

CHAIRWOMAN OLSON: Seeing none, I'd ask for a roll call vote.

MR. ROATE: Thank you, Madam Chair.

Motion made by Senator Demuzio; seconded by
Ms. Murphy.

Senator Burzynski.

MEMBER BURZYNSKI: I vote aye. I think this is a good way to go in the future, and I'm pleased to support it.

MR. ROATE: Thank you.

Senator Demuzio.

MEMBER DEMUZIO: I'm going to vote aye, also, based on Senator Burzynski's comments.

MR. ROATE: Thank you.

Mr. Johnson.

MEMBER JOHNSON: I'm going to vote yes, as well, based on the testimony here today.

MR. ROATE: Thank you.

Mr. McGlasson.

MEMBER MC GLASSON: Yes, based on testimony.

MR. ROATE: Thank you.

Ms. Murphy.

MEMBER MURPHY: Yes, based on testimony.

MR. ROATE: Thank you.

Mr. Sewell.

VICE CHAIRMAN SEWELL: I'm going to abstain on this one.

We don't have a category of service in the
rules called "Home Dialysis." But based on the testimony, it seems like something that is a viable option for a significant number of patients. And I don't want to vote against it, but I don't think I can vote for it because of some of the other findings.

So I abstain.

MR. ROATE: Thank you, sir.

Madam Chair.

CHAIRWOMAN OLSON: I'm going to vote yes.

I was actually given the assignment of being in charge of patient advocacy and access on this Board, and I think this gives patients another choice.

And I applaud what you're doing. I think it's important that patients have a choice.

MR. ROATE: Thank you, Madam Chair.

That's 6 votes in the affirmative, 1 vote to pass.

CHAIRWOMAN OLSON: The motion passes.

Congratulations.

DR. SALAKO: Thank you.

MR. SHAZZAD: Thank you.

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CHAIRWOMAN OLSON: Okay.

We don't have any applications subsequent to deny.

We don't have any other business.

Are we going to do rules with Jeannie not here or --

MR. MORADO: We can.

CHAIRWOMAN OLSON: Okay.

MR. MORADO: So we're going to be seeking approval to move forward with the filing of changes to the 1130 rules specifically.

This is going to be a change to 1130.525, which requires a health care facility that's discontinuing to give notice to local media. This was put forth by a representative, I believe, from the Rockford area.

And what we're looking to do is make a change in rule that's already been made in statute, so we're seeking a motion to move forward with the filing at this time.

CHAIRWOMAN OLSON: May I have a motion.

MEMBER BURZYNSKI: So moved.

CHAIRWOMAN OLSON: Second?

MEMBER MURPHY: Second.
CHAIRWOMAN OLSON: All those in favor say aye.

(Ayes heard.)

CHAIRWOMAN OLSON: Motion passes.

Handbook, Juan?

MR. MORADO: Yes. So the handbook.

I presented before you back in Bloomington and laid out a bunch of different directives that had been given to IDPH employees and made a number of suggestions on whether or not those things should be incorporated into the handbook.

In front of you you have a copy of the updated handbook. What I did with regard to two of those directives specifically was take that language and insert it right into our handbook.

So there's nothing new. You have copies of the handbook; you have copies of the old directives. Specifically I made changes regarding personal and professional conduct and against fraud prevention.

So nothing new, nothing controversial here. We're just looking for approval of the updated handbook.

CHAIRWOMAN OLSON: May I have a motion to approve the updated handbook.
MEMBER JOHNSON: So moved.

VICE CHAIRMAN SEWELL: So moved.

MEMBER JOHNSON: Second.

CHAIRWOMAN OLSON: All those in favor say aye.

(Ayes heard.)

CHAIRWOMAN OLSON: The motion passes.

You have your financial report --

THE COURT REPORTER: Use your mic, please.

I can't hear you.

MEMBER BURZYNSKI: Oh, my.

CHAIRWOMAN OLSON: I made it all the way this far.

You have your financial report to review.

If you have any questions, please contact Courtney.

The IDPH/HFSRB intergovernmental agreement.

Juan.

MR. MORADO: I'm seeking a motion to get approval for the IGA at this time. There were two changes made and one edit.

The changes made took the language that already exists and was approved by this Board last year and put it in a different section. That was made by the -- at the request of IDPH.
The second edit -- or second change, rather -- would make the reporting of financial reports go from a monthly basis to a quarterly basis.

Courtney, I believe, had a discussion with Bill about that already. As you will notice from your financial reporting, they already provide it on a quarterly basis. So we've also been told that, in the event that we need information from the finance folks, that we can request it.

So other than that, there's no other changes to the IGA, and we're seeking a motion for its approval at this time.

CHAIRWOMAN OLSON: May I have a motion to approve the intergovernmental agreement.

MEMBER DEMUZIO: Motion.

CHAIRWOMAN OLSON: Second, please.

MEMBER MURPHY: Second.

CHAIRWOMAN OLSON: All those in favor say aye.

(Ayes heard.)

CHAIRWOMAN OLSON: Motion passes.

I'm looking for a motion to recommend that the executive meeting transcripts from 2015 and 2016
remain closed.

    MR. MORADO: Yes.

    CHAIRWOMAN OLSON: May I have a motion.

    MEMBER JOHNSON: So moved.

    VICE CHAIRMAN SEWELL: Second.

    CHAIRWOMAN OLSON: All those in favor say aye.

    (Ayes heard.)

    CHAIRWOMAN OLSON: The motion passes. The exec meeting transcripts will remain closed.

    MR. MORADO: And very, very quickly, just so the folks who don't -- aren't aware of why we're doing this -- the Open Meetings Act requires us to, on an annual basis, review our executive closed minutes and then determine whether or not we want to keep them closed or release them to the public.

    CHAIRWOMAN OLSON: You have been given a list of the 2018 meeting dates with potential locations.

    MS. AVERY: Yes, potential locations.

    The only major change that diverts from the past is the April meeting, which was normally held in Bloomington-Normal. I thought it might be nice
if we met in Springfield for that April meeting during the time that the legislature is in session. Just in case we want to do visits or say hello.

CHAIRWOMAN OLSON: You don't think they're going to be in session in the summer; hm-m?

MS. AVERY: Yes, I do.

CHAIRWOMAN OLSON: Okay. So you have those meeting dates and times. Please put them on your calendar.

Okay. I'm looking for a motion to correct St. Anthony's Hospital, Effingham. They want to correct their profile for the 2014-2015 AHQ profiles.

May I have a motion to approve that correction.

That's right, Jesse? That's what we're doing; right?

MR. NUSS: I'm sorry?

CHAIRWOMAN OLSON: Is it Jesse or Nelson?

MR. ROATE: Yes.

CHAIRWOMAN OLSON: May I have a motion to approve those corrections.

MEMBER MURPHY: So moved.

CHAIRWOMAN OLSON: And a second, please.

MEMBER JOHNSON: Second.
CHAIRWOMAN OLSON: All those in favor say aye.

(Ayes heard.)

CHAIRWOMAN OLSON: I would entertain a motion to adjourn.

MEMBER JOHNSON: So moved.

CHAIRWOMAN OLSON: Oh, wait, wait, wait. All right.

MS. AVERY: Okay. I'll just go real quick. We're almost done.

For the legislative update, I just wanted to let you all know that House Bill 763 is on concurrence and, hopefully, it will be signed this week or next week. That's our initiative for the Board.

VICE CHAIRMAN SEWELL: Do we get paid?

MS. AVERY: No. No pay.

MEMBER BURZYNSKI: So moved.

CHAIRWOMAN OLSON: May I have a motion to get paid -- may I have a motion to adjourn.

MEMBER JOHNSON: So moved.

CHAIRWOMAN OLSON: And a second?

MEMBER MURPHY: Second.

CHAIRWOMAN OLSON: All those in favor
say aye.

(Ayes heard.)

CHAIRWOMAN OLSON: We're adjourned. See you in Springfield.

(Off the record at 4:53 p.m.)
CERTIFICATE OF SHORTHAND REPORTER

I, Melanie L. Humphrey-Sonntag, Certified Shorthand Reporter No. 084-004299, CSR, RDR, CRR, CRC, FAPR, 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 this 5th day of July, 2017.


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**Transcript of Full Meeting**

**Conducted on June 20, 2017**

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**Conducted on June 20, 2017**

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**Transcript of Full Meeting**

**Conducted on June 20, 2017**

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