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ILLINOIS DEPARTMENT OF PUBLIC HEALTH

HEALTH FACILITIES AND SERVICES REVIEW BOARD

OPEN SESSION

REPORT OF PROCEEDINGS

Bloomington-Normal Marriott Hotel
201 Broadway Street
Normal, Illinois 61761

March 11, 2014
9:03 a.m. to 3:24 p.m.

BOARD MEMBERS PRESENT:

MS. KATHY OLSON, Chairperson;

MR. JOHN HAYES, Vice Chairman;

MR. PHILIP BRADLEY;

DR. JAMES J. BURDEN; and

SENATOR DEANNA DEMUZIO.

Reported by: Paula M. Quetsch, CSR, RPR
Notary Public, Kane County, Illinois

EX OFFICIO MEMBERS PRESENT:

MR. DAVID CARVALHO, IDPH, and

MR. MIKE JONES, IDHFS.

ALSO PRESENT:

MR. FRANK URSO, General Counsel;

MS. COURTNEY AVERY, Administrator;

MR. NELSON AGBODO, Health Systems Data Manager;

MS. CLAIRE BURMAN, Rules Coordinator;

MS. CATHERINE CLARKE, Board Staff;

MR. MICHAEL CONSTANTINO, IDPH Staff;

MR. BILL DART, IDPH Staff; and

MR. GEORGE ROATE, IDPH Staff.

I N D E X

I N D E X
(Continued.)

CHAIRPERSON OLSON: I'd like to call the meeting to order. Can we have roll call, please.

MR. ROATE: Yes, ma'am.

Kathy Olson.

09:03:02 CHAIRPERSON OLSON: Present.

MR. ROATE: John Hayes.

MEMBER HAYES: Here.

MR. ROATE: Philip Bradley.

MEMBER BRADLEY: Here.

09:03:06 MR. ROATE: Dr. James Burden.

MEMBER BURDEN: Here.

MR. ROATE: Senator Deanna Demuzio.

MEMBER DEMUZIO: Here.

MR. ROATE: Dale Galassi is absent;

09:03:14 Justice Alan Greiman is absent; David Penn is absent; and Richard Sewell is absent.

CHAIRPERSON OLSON: Thank you. The first order of business is executive session. May I have a motion to go into executive session pursuant to

09:03:29 2(c)(11) and 2(c)(1) of the Open Meetings Act.

MR. URSO: So moved.

CHAIRPERSON OLSON: Motioned. May I have a second.

MEMBER HAYES: Second.

CHAIRPERSON OLSON: All those in favor.

(Ayes heard.)

CHAIRPERSON OLSON: Opposed.

(No response.)

09:03:43 CHAIRPERSON OLSON: We are now in executive session. We will be -- can we give an approximate time? Tops 45 minutes. We'll need everybody to leave the room while we're in executive session. Thank you. We'll try to be speedy.

09:03:59 (At 9:04 a.m., the Board adjourned into executive session. Open session proceedings resumed at 9:41 a.m., as follows:)

CHAIRPERSON OLSON: Okay. We'll now go

09:43:52 back into open session.

The next order of business is Compliance Issues/Settlement Agreements/Final Orders.

MR. URSO: Yes. Thank you, Madam Chair.

The staff is requesting that four matters be

09:44:59 referred to legal counsel for review of filing notice of noncompliance, which includes sanctions detailed and specified in the Board's rules.

Those four facilities are Ottawa Pavilion, Ltd., Permit No. 12-063; Center for Comprehensive

Services, Incorporated, Permit No. 13-051; Kishwaukee Community Hospital, Permit No. 9-069; and the last one is Gold Coast Surgicenter, Permit No. 13-017.

CHAIRPERSON OLSON: May I have a motion to refer these four items to legal counsel?

09:45:47

MEMBER DEMUZIO: Motion.

MEMBER BURDEN: Second.

MR. ROATE: Motion made by Ms. Demuzio, seconded by Dr. Burden.

Senator Demuzio.

09:46:01

MEMBER DEMUZIO: Yes.

MR. ROATE: Dr. Burden.

MEMBER BURDEN: Yes.

MR. ROATE: Mr. Bradley.

MEMBER BRADLEY: Yes.

09:46:07

MR. ROATE: Mr. Hayes.

MEMBER HAYES: Yes.

MR. ROATE: Chairman Olson.

CHAIRPERSON OLSON: Yes.

MR. ROATE: Five votes in the affirmative.

09:46:13

CHAIRPERSON OLSON: Final orders?

MR. URSO: Madam Chair, Members, I'm requesting a motion to approve final decision in Phoenix Medical Center, Incorporated. It's docketed as

HFSRB 13-111, as well as HFSRB 13-16.

CHAIRPERSON OLSON: May I have a motion to approve these two final orders?

MEMBER DEMUZIO: Motion.

09:46:36 MEMBER BURDEN: Second.

MR. ROATE: Motion made by Senator Demuzio, seconded by Dr. Burden.

Senator Demuzio.

MEMBER DEMUZIO: Yes.

09:46:42 MR. ROATE: Dr. Burden.

MEMBER BURDEN: Yes.

MR. ROATE: Mr. Bradley.

MEMBER BRADLEY: Yes.

MR. ROATE: Mr. Hayes.

09:46:47 MEMBER HAYES: Yes.

MR. ROATE: Chairwoman Olson.

CHAIRPERSON OLSON: Yes.

MR. ROATE: Five votes in the affirmative.

09:46:52 CHAIRPERSON OLSON: Motion passes.

May I have a motion to approve the agenda?

MEMBER BURDEN: So moved.

MR. CARVALHO: Second.

CHAIRPERSON OLSON: We'll do this with a

voice vote. All in favor say aye.

(Ayes heard.)

CHAIRPERSON OLSON: Opposed.

(No response.)

09:47:07 CHAIRPERSON OLSON: The motion passes.

I'd like a motion to approve the transcript from the special meeting on February 20th, 2014. May I have a motion?

MEMBER DEMUZIO: Motion.

09:47:16 MEMBER BURDEN: Second.

CHAIRPERSON OLSON: In all favor say aye.

(Ayes heard.)

CHAIRPERSON OLSON: Motion passes. The

09:47:21 transcripts are approved as submitted.

The next order of business is public participation.

Courtney?

MS. AVERY: Good morning. First person

09:47:39 up for public participation is Project 13-048, Aegean Transitional Care of Lockport, Ben Benson, Darren Deskin, Bill Malony.

CHAIRPERSON OLSON: Good morning, gentleman. Please sign in and I ask that you please

limit your comments to two minutes.

Nelson, are you going to keep time, please?

MR. AGBODO: Yes.

MR. BENSON: My name is Ben Benson. I'm
09:48:40 the city administrator for the City of Lockport, certainly a proponent of the Lockport Center for Transitional Care.

You know, this is not about heads in beds nor even about feets in the sheets. Maybe we can put some
09:48:55 butts in the seats, but really it's about not having to drive too far on our streets.

While there are certain facilities in the region that are 30 minutes away or more, this proposed center is not a nursing home; it's not a pop-up
09:49:08 physical therapy. This is a medical transitional care center in Lockport. "Transitional" means serving those patients leaving hospitals to rehabilitative services. This is not about a long-term care facility; this is about service and getting people back to being healthy.
09:49:27 Those in need in Lockport have felt underserved for quite some time. Before the 355 extensions were built, Lockport was kind of left in a doughnut hole. Communities like Lamont, Crest Hill, and Joliet grew, and their facilities they desired they

received. Now we have two new exits on 355. We have over 25,000 residents and have two exits, and our trade area is probably about 75,000 people within a 20-minute radius.

09:49:53 I understand there was a study done in 2013, but like in many studies, I think it was flawed. It used 2010 data and now here we are four years later, and I can assure you we've had a lot more growth. The center, even if it was approved today, wouldn't be

09:50:10 built for two years. So we would be six years removed from that study.

And Lockport is a proud Will County community. Will County was the fastest growing community before the economic crash, and it will quickly be rebounding

09:50:23 when this economy changes. We have over 350 housing starts pending, 240 multifamily units, 80 single-family homes, and with our regular growth projections, we are estimating another 500 housing starts in the next year, and I would challenge you to look and see if anyone can

09:50:42 have that statement within an hour of this facility.

So our population is surging.

MR. AGBODO: Two minutes.

MR. BENSON: Okay. And I urge you to please give Aegean Medical Center Transitional Care

Center Lockport a clear look. You will see the justification for certificate of need and help us start helping those in need.

Thank you.

09:51:01 CHAIRPERSON OLSON: Thank you.

MR. MALONY: Good morning. Thank you for providing us with this opportunity to speak to you. My name is Bill Malony. I'm a resident of the city of Lockport, and my purpose in being here this morning is 09:51:15 to express my support for the proposed AegeanMed health care facility.

As the baby boomer generation of American citizens continues to age, the demand for services this facility will provide will only increase, and there is 09:51:28 no single postoperative health care facility anywhere in proximity to Lockport that has available the array of rehabilitation services that this state of the art facility will provide. At a time when hospitals tend to discharge surgical patients sicker and sicker than 09:51:45 ever before, the need for this facility should be readily apparent.

Just last year my wife had a total shoulder replacement surgery, and her inpatient physical rehabilitation at the hospital was limited to just

five days. She wasn't really ready to come home, but we had no other option. She would have been an ideal patient for this facility if it existed at that time.

And, also, it should be made clear that the 09:52:15 AegeanMed health care facility is not intended to be another traditional long-term nursing home for terminally ill patients. Its purpose is to provide short-term transitional care and restorative care for postoperative patients that ultimately intend to return 09:52:29 to their homes and resume their place in society.

Thank you.

CHAIRPERSON OLSON: Thank you, sir.

MR. DESKIN: Good morning. I'm Dr. Darren Deskin. I am a chiropractor in the city of 09:52:39 Lockport. I am also alderman for the City of Lockport. I can assure you that we had a unanimous agreement with all the City council and the mayor when we approved this project, the Aegean Medical Center.

One of the things I've read -- I've read the 09:52:57 exact same thing you have in your packet, all three pages of it, and one of the things I'd like to point out which is on page 2, the need for the project. And really this is what we're all here about is the need for the project.

Within your records here it says there's a calculated excess of 169 skilled care beds in calendar year '15 in the Will County long-term care planning area. This is not a long-term care facility.

09:53:25 Throughout this document that you have before you it talks about long-term care facilities.

I'm also quite familiar with three of the -- three of the facilities that are on pages 2 and 3 of your packets. My wife has worked at three of these

09:53:42 centers. All three of these centers that she has worked at, the one center is -- probably the most modern one is 1992, 1993. These facilities do not and cannot provide the same type of care that the Aegean Transitional Care facility can and will and nor will

09:54:06 they ever have the capability of doing so.

So there is a significant need for this type of a facility in Lockport, and it will serve the entire Will County, part of DuPage County, Cook County planning area. We are in the middle of three major

09:54:28 highways, I-355, I-55, and I-80. 6 miles down south of us is Silver Cross Hospital which can provide some of this type of care but for an extremely limited amount of time. We're talking about a facility that will be six, seven, maybe eight weeks tops. This is not a

long-term.

MR. AGBODO: Two minutes.

MR. DESKIN: Thank you. I ask for your support.

09:55:35 CHAIRPERSON OLSON: Thank you.

MS. AVERY: Next for public participation is DaVita Belvidere Dialysis, Larramie Beecher, Raul Monteagudo, Melaney Dembicky.

CHAIRPERSON OLSON: Make sure you all

09:56:30 sign in. Just put it really close and try to talk as loud as you can.

MR. MONTEAGUDO: Good morning. My name is Raul Monteagudo. I am here because I need support for dialysis at DaVita. I live in Belvidere, Illinois,

09:58:39 and I have five years go to Rockford, and I don't have transportation and need to go at 9:00 in the morning and be back to my home 4:00 the afternoon. That takes too much time. It's too much time for -- seven, eight hours a day is too much time. I've lost my vision and

09:59:21 I need the clinic the Belvidere.

CHAIRPERSON OLSON: Thank you, sir.

MR. BEECHER: My name is Larramie Beecher. I live in Belvidere. I live alone and we have difficulty -- I go from 5:00 in the morning until 9:00

for my dialysis. There are no buses running between Belvidere and Rockford at that time of day, and I have to drive myself in the dark, and I can't see that well in the dark so it's difficult. And, of course, the
10:00:06 weather this year has been really difficult. I'm looking at from 4 to 8 inches tomorrow morning when I go. I'm just lucky I've got a four-wheel drive vehicle.

But, like I say, it's difficult getting there.
10:00:21 It's hard to get friends to get up at 4:30 in the morning to take me over there, spend six or eight hours out of their day to take me over and come back and pick me up, so I have to drive myself. And there's no buses, like I say, so I go through that every other
10:00:41 day. I have to go and take care of myself. I live alone like I said. That's about it.

CHAIRPERSON OLSON: Thank you, sir.

MS. DEMBICKY: Hi. My name is Melaney Dembicky. I'm the transportation supervisor
10:01:01 for Boone County Transportation. We have four senior living facilities, one assisted-living facility for seniors, and three nursing homes. Last year our buses served 951 unduplicated riders, provided 25,918 rides, traveling 146,871 miles for the year.

Last year we provided para transits -- which I want to say are 90 percent dialysis patients -- 1,055 rides at 11,435 miles of travel. This year with four months to go in our fiscal year we've already 10:01:41 provided 1,037 rides with 11,407 miles of travel. This is due to the increase in the number of dialysis patients. We travel to Rockford with dialysis patients sometimes four times a day, tying up our buses up for over an hour for each trip to get clients to dialysis 10:02:06 and back. Just this week I received two more requests to go to dialysis.

These numbers do not include clients that have to be denied transportation because they don't qualify for the transportation under para transit rules 10:02:18 set by Rockford Mass Transit District. They must be within a mile of the Rockford Mass Transit District fixed route to qualify. This excludes clients that we normally service from Capron, Poplar Grove, Garden Prairie, and even some clients on the outskirts of 10:02:36 Belvidere.

If we had a dialysis facility in Belvidere, those clients could be transported for service. Also, the cost would be less for the clients that are being serviced now. The cost for a bus ride in Boone County

is $2 each one-way trip. Seniors are by donation, so if they cannot afford it, they don't have to pay. The cost for a para transit ride is $3 each trip. If a person doesn't qualify for para transit, the cost is
10:03:06 50 cents a mile --

MR. AGBODO: Two minutes.

MS. DEMBICKY: -- or about 5- to $8 or more each one-way trip, or they'd have to take a cab or have family members. I've had several people call
10:03:17 crying asking me to please transport them, and I have to deny them, which breaks my heart.

I also want to mention the Rockford Mass Transit District is contracted through June of '15 to service Belvidere. If the service does not continue
10:03:30 due to funding, our para transit service to Rockford would not continue, leaving all of those dialysis patients to find their own means of transportation.

Having a dialysis facility in Belvidere would be such a big help to clients needing dialysis. It
10:03:49 would decrease the time of travel --

CHAIRPERSON OLSON: Please conclude your remarks at this time.

MS. DEMBICKY: -- open transportation service to clients that do not now qualify for the

service, not to mention freeing up transportation waiting time for clients within Boone County and keeping them off the bus as long as they have to travel.

CHAIRPERSON OLSON: Thank you.

10:04:09 MS. AVERY: Next is 13-072, NorthPointe Health and Wellness Campus, Nancy Garry, Jim Moore, David Krienke, Dr. Patel, Dr. Minore, Donald Schreiner, and Peter Marks.

CHAIRPERSON OLSON: Be sure to sign in.

10:05:32 MS. GARRY: Good morning. My name is Nancy Garry. I represent Rockford Endoscopy Center's opposition to the construction of an ASTC on the NorthPointe campus in Rockton, Illinois. We wish to clarify some misrepresentations regarding our

10:05:43 facility's capacity and efficiency.

The applicant states that Rockford Endoscopy Center does not have excess capacity because they calculate we can justify nine rooms for the number of procedures we performed in 2012. The 1500-hour

10:05:57 standard is not an economically viable benchmark for an endoscopic operation, and no independent group would construct nine rooms for our volume.

In fact, when we wanted to expand our practice, we changed our work flow to increase

efficiency and improve our use of existing space. With this change, we were able to double our capacity without adding space, and, as we stated previously, we are now operating at about 75 percent capacity. If BMH
10:06:26 were to make similar changes in their operation, they would have 1,463 hours of GI need for the two rooms on their Beloit campus. Improved efficiency in their operation would prevent the unnecessary construction of these rooms.

10:06:40 We also expressed concern regarding the high fees in the applicant's charge master. They responded that their fees are irrelevant because reimbursement would be the same as current in-market providers. This may be true if the proposed facility
10:06:53 submits bills as an ambulatory surgery center. However, if they bill as a hospital outpatient department, reimbursement is almost double. The lack of commitment from BMH to bill services at ASC rates leaves this option open, and, if taken, significantly
10:07:08 increases the cost of health care services to both patient and payers.

We support this Board's goals of promoting cost containment, better management, and improved planning to prevent unnecessary construction or

modification of health care facilities. We respectfully ask that you deny this application.

Thank you.

CHAIRPERSON OLSON: Thank you.

10:07:31 Jim Moore is next.

MR. MOORE: Good morning again. My name is Jim Moore. I was born in Rockford, Illinois, and lived my first 55 years there. Some people claim I should be a bionic man because of all the surgeries

10:07:47 that have been performed on my body. I am not a bionic man, but I am alive today because of the advances in the medical profession.

A couple of surgeries were performed at ambulatory surgery center. I've learned firsthand that

10:08:02 having procedures completed at a surgery center was considerably less stressful just because I didn't need to go to the hospital.

My primary doctor in Rockford retired. In the meantime I moved to Roscoe. I preferred finding a

10:08:15 local doctor with an office there. I was pleased when NorthPointe was constructed. I now have a primary doctor located there. The change saved me many 30-mile round-trips to and from Rockford.

I have used the services of five other

doctors through the Beloit Health System. Now that I'm 80, the close proximity of doctors and medical facilities is even more important to me. Like many my age, I am more stressed about things that never
10:08:50 bothered me before.

I would need to travel to Beloit Memorial Hospital on March 17th for another procedure. I would certainly have preferred doing this at an ambulatory surgery treatment center at NorthPointe. NorthPointe
10:09:04 feels like my second home. Whether I'm in the fitness center or the medical side of the building, the staff is very professional and friendly.

From my point of view, an ambulatory surgery treatment center at NorthPointe would add another
10:09:18 service for me and my friends that if necessary could be performed there with a minimum of stress and much less travel.

Thank you for your attention.

CHAIRPERSON OLSON: Thank you.

10:09:29 David?

MR. KRIENKE: Good morning. My name is David Krienke. I'm the Village president of the Village of Roscoe.

MS. AVERY: Mr. Krienke, can you pull

the mic closer?

MR. KRIENKE: On behalf of the citizens of Roscoe and the Village Board, I'm pleased to be here to speak in support of the development of the
10:10:00 ambulatory surgical center to be located on the NorthPointe campus in the Village of Roscoe.

NorthPointe and Beloit Memorial have been very involved in bringing community awareness of health wellness issues to our region. They have booths and
10:10:19 displays at local events; they have partnered with Hononegah High School to assist with its sports and fitness training programs, the use of the swimming pool at Hononegah High School for the swim team, and provide athletic training for Hononegah sports teams.

10:10:46 Beloit Memorial has filled the need of our community in the expansion of these services, provides high quality of care to the residents of Roscoe, conveniently located, accessible to the residents of northern Illinois, supported by all three northern
10:11:13 Illinois communities of Roscoe, Rockton, and South Beloit.

Plus, they have -- to the Village of Roscoe they provide financial support. In 2012 to the taxing body NorthPointe paid $818,413.88 in property taxes.

To tell you what that means to the Village of Roscoe, the Village of Roscoe's portion was $54,000 in 2012, and I believe that they provide great health care for --

MR. AGBODO: Two minutes.

10:11:55 MR. KRIENKE: -- the region, and, also, as part of our community it's -- I think that they have it right.

CHAIRPERSON OLSON: Thank you.

Dr. Patel.

10:12:13 DR. PATEL: Good morning. My name is Hemal Patel, and I'm a gastroenterologist at Beloit Health since August 2012. I'm here today to support the proposed surgery center at the NorthPointe facility in Roscoe, Illinois.

10:12:31 At present we have two GI procedure rooms at Beloit Memorial Hospital for three gastroenterologists, including myself. We had a little over 3800 procedures in 2013, with about 80 percent of those being outpatient GI procedures. Our current GI suite does need

10:12:48 modernization to provide quality and efficient care to our patients.

The new surgery center will help our patients by providing them easy access in and out of the facility, will provide more comfort and privacy before,

during, and after the procedures, will avoid delays in patient care, and will also give more choices in the sense of timing of the procedure.

The proposed surgery center will really help
10:13:24 our state line GI patients to get quality patient care at a modern facility. I thank you for your time, and I ask for your support for this facility.

Thank you.

CHAIRPERSON OLSON: Thank you, Doctor.

10:13:37 Dr. Minore.

DR. MINORE: My name is Stephen Minore, and I'm the president and a physician practicing pain management at Rockford Ambulatory Surgery Center.

The State Agency report repeatedly fails to
10:13:54 state both findings of fact and conclusions at law that were presented during the public hearing process. The State Agency report is primarily a cut and paste of the CON rules and the applicant's statements.

For example: Fact, most (meaning all but one
10:14:09 or two) of the surgeons listed in the application are not on staff at an Illinois licensed hospital and under Illinois law cannot perform any surgical procedures in any Illinois ASTC. This is both a fact and a conclusion not mentioned in the State Agency report.

The applicant states they cannot generally allow their physicians to have privileges in other provider settings. This restricts patient choice regarding the facility provider for all patients, including Medicare
10:14:39 patients.

Fact: The applicant refuses to commit that it will only charge Medicare patients at the lower ASC rate. If NorthPointe adopts Hospital Outpatient Department rates, the cost of care for the average
10:14:53 Medicare patient will increase by over 72 percent, as that is the higher amount that CMS pays hospitals over ASCs for the same identical procedure. These facts were presented in testimony but are not included in the State Agency report.

10:15:11 Fact: The applicant posts inefficient and inaccurately long OR case times to justify the number of rooms in their application. This will result in excess capacity of operating rooms, further inefficiency, and facility duplication in the
10:15:26 geographic service area to the detriment of Illinois citizens.

Fact: Rockford Ambulatory Surgery Center has an open medical staff, welcomes the Beloit Memorial surgeons, and can accommodate all Beloit Memorial

outpatient surgical cases without spending millions on the construction of an unneeded new outpatient surgical facility.

MR. AGBODO: Two minutes.

10:15:51 DR. MINORE: This is not reflected in the State Agency report, and I state this fact for the record.

In conclusion, a review of this application reveals that it will result in unnecessary duplication 10:16:02 of services and facilities in the targeted health service area and an unnecessary expenditure of scarce health care dollars in order to duplicate those facilities. It will provide a convenient alternative for Beloit Hospital to utilize while they remodel and 10:16:18 upgrade a hospital in Wisconsin at the ultimate expense of providers and citizens in northern Illinois. I strongly urge that you deny this application.

Thank you.

CHAIRPERSON OLSON: Thank you.

10:16:31 Donald Schreiner.

MR. SCHREINER: Good morning. My name is Don Schreiner. I am the chief executive officer of Rockford Orthopedic Surgery Center. Rockford Orthopedic Surgery Center is a joint venture between

OSF-St. Anthony Hospital in Rockford and Rockford Orthopedic Associates, one of largest medical groups in Winnebago County.

I speak today in strong opposition to the
10:16:54 application for permit filed by Beloit Health System, Inc., to establish a multispecialty ambulatory surgical treatment center at 5606 East Rockton Road, Roscoe, Illinois.

Simply put, we believe that the application
10:17:05 should be denied for a number of reasons:

First, by its own admission, the applicant has failed to satisfy Section 1110.1540(f) of this review board's rules. There are several underutilized surgery centers and outpatient hospital departments in
10:17:23 the relevant planning area, and outpatient surgical services are clearly available in the relevant planning area.

Unfortunately, instead of addressing -- directly addressing these shortcomings, the applicant
10:17:35 asserts that the clear wording of Section 1110.1540(f) can be ignored because the applicant believes that the other providers in the relevant planning area will not be impacted.

To state the obvious, the applicant is

mistaken in its belief. The other area providers will be negatively impacted, and the review board's rules specifically assume that a provider will be negatively impacted if Section 1110.1540(f) is not satisfied. In
10:18:10 other words, the review board cannot ignore Section 1110.1540(f) and rely on the "trust me" statements set forth by the applicant.

Second, the applicant asserts that it is prepared to transfer 3,467 surgical and procedural
10:18:28 cases from its main hospital campus in Beloit, Wisconsin, to the proposed surgery center in Roscoe.

Leaving aside whether the patients will actually agree to be transferred from a hospital-based setting in Wisconsin to an ambulatory-based setting in
10:18:38 Illinois --

MR. AGBODO: Two minutes.

MR. SCHREINER: -- the proposed transfer of so many cases will completely obliterate the applicant's utilization figures at its existing
10:18:52 hospital in Beloit, Wisconsin.

According to the applicant's own data, the proposed cases for the proposed surgery center comprise approximately 48 percent of the applicant's case load at its main hospital in Beloit, Wisconsin. If these

3,467 cases leave the main hospital in Beloit for the proposed surgery center in Illinois, the applicants will have underutilized operating rooms in Wisconsin. If an Illinois hospital were to propose this maneuver, 10:19:16 their actions would be immediately rejected --

CHAIRPERSON OLSON: Mr. Schreiner, can you please conclude --

MR. SCHREINER: -- because they would cause underutilization at their own hospital.

10:19:21 Third, the decision to transfer outpatients from the applicant's main campus in Wisconsin --

CHAIRPERSON OLSON: Mr. Schreiner, will you please conclude your remarks. You're over your two minutes.

10:19:33 MR. SCHREINER: Okay.

CHAIRPERSON OLSON: Thank you. Just tie it up.

MR. SCHREINER: I'll read very quickly.

Fourth, and somewhat related to the above 10:19:41 point, the applicant has submitted an affidavit that states that the applicant will not increase its operating room capacity at its main hospital in Beloit until such time as the proposed surgery center reaches full utilization. Given that the applicant's main

hospital in Beloit will be materially below the utilization standards for operating rooms because of the transfers of nearly half its patients, the affidavit is completely meaningless.

10:20:02 CHAIRPERSON OLSON: Mr. Schreiner, I need you to conclude your remarks, please. Everybody gets two minutes and we're closing in on three minutes here.

MR. SCHREINER: Okay. Well --

10:20:15 CHAIRPERSON OLSON: I'm sorry. That's the rule. Can you just conclude for us?

MR. SCHREINER: Okay. I'll just read the last paragraph.

Based on the foregoing reasons and for the

10:20:27 reasons we previously outlined in the public hearing and in our written objections, we strongly oppose the establishment of the proposed surgery center in Roscoe and urge the Board to deny project.

CHAIRPERSON OLSON: Thank you. And your

10:20:44 comments were in the public hearing.

MR. SCHREINER: Thank you.

CHAIRPERSON OLSON: Dr. Marks.

DR. MARKS: Good morning. My name is Peter Marks. I'm a cardiothoracic vascular surgeon at

Beloit Memorial Hospital and thoracic surgeon at Rockford Memorial Hospital, and I am in support of the ambulatory care center at NorthPointe.

With the increase in cardiac and thoracic
10:21:06 procedures at Beloit Memorial Hospital, we need a modernized and dedicated OR suite which will in turn benefit the number of rooms available for outpatient procedures.

MS. AVERY: Can you pull the mic closer?
10:21:14 The court reporter is having a hard time hearing you.

DR. MARKS: On top of this, when a cardiac procedure is completed, the room must be available for a period of several hours past the procedure in case of any postoperative issues, again
10:21:33 decreasing the number of ORs available for outpatient procedures and at times postponing or cancelling those outpatient procedures at great convenience to those patients.

Thank you. I'm in support of this
10:21:47 application for this outpatient surgery center.

CHAIRPERSON OLSON: Thank you everybody. That concludes the public participation section of our meeting this morning. Would the Board members like a quick break?

(No response.)

CHAIRPERSON OLSON: Next is postpermit items approved by the Chairman.

Mr. Constantino.

10:22:25 MR. CONSTANTINO: Madam Chairwoman, we need copies of that testimony that was provided for the court reporter.

CHAIRPERSON OLSON: Anybody who has a copy of their testimony if you'd please put it on this

10:22:37 front table. Even if it's just like chicken scratch outline, it helps her to complete the transcript.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The Chairwoman has approved two permit

10:23:16 renewals. Permit Renewal No. 12-003 Holy Family Villa in Palos Park. It's a four-month permit renewal.

The second permit renewal is Permit Renewal No. 11-018 for Blessing Hospital in Quincy. It's a six-month permit renewal.

10:23:38 Thank you, Madam Chairwoman.

CHAIRPERSON OLSON: Thank you.

Mr. Urso is going to give us a reminder of the Board meeting guidelines.

MR. URSO: Thank you.

The basis for these remarks are in the Board's rules, as well as in the Health Facilities Planning Act.

These general guidelines pertain to formal
10:24:02 Board meetings and do not apply to other Board-sponsored meetings, including public hearings or rules development meetings.

Only permit or exemption applicants and their staff, attorneys, or consultants can testify at a Board
10:24:18 meeting during the time that the application is being considered by the Board. Other individuals attempting to be heard at the Board meeting have the opportunity to speak in the public participation segment.

The Board chair or a majority of Board
10:24:33 members can designate time limits on any and all Board meeting agenda items, including regularly scheduled agenda items.

The transcript will serve as the administrative record of the board meeting.

10:24:46 Pursuant to the Health Facilities Planning Act, five members of the Board shall constitute a quorum. Affirmative vote of 5 of the board members shall be necessary for any action that's taken by a vote. And I want to note for the audience that today

we have five Board members, so anything that passes today requires all the Board members that are present today in an affirmative way.

The validity of comments. Written comments 10:25:17 filed with the Board or oral statements made under oath regarding any matters that are subsequently found to be false or inaccurate will serve as a basis for a Board investigation. The Board may require the person who made the false or inaccurate comments or statements to 10:25:36 appear before the Board. The Board may censure that person, and censure is defined in the Board's rules as a formal and public reprimand issued by the Board. In addition, the Board may determine that person to be ineligible to provide written comments or oral 10:25:58 statements concerning any future Board considerations.

The following comments pertain to presenting new information. The Board will not accept any new information presented by applicants or any of their representatives concerning an application during the 10:26:18 board meeting at which the application is being considered by the Board. The exceptions to that rule about not providing new information applies when someone is deferred by the Board or the applicant defers, then new information can be filed. If the

applicant receives an intent to deny, new information can be provided, or if an applicant is responding to statements made during the public participation period of the meeting where that project is being considered,
10:26:53 new information can be provided.

Any new information that is pertinent to an application and allowable shall be submitted in writing to the Board staff within the allowable time frames provided in the Board's rules. New information
10:27:09 submitted by e-mail or fax will not be accepted.

Thank you.

CHAIRPERSON OLSON: Thank you, Frank. In other words, don't lie to us. We don't like it.

Discussion of Settlement Agreements.

10:27:28 Mr. Urso.

MR. URSO: Thank you, Madam Chair.

This discussion has to do with settlement agreements that are in front of the Board, and it has to do with violations of Board-approved settlement
10:27:46 agreements.

Initially if a party does not comply with the Board's act and rules, ultimately, the Board, if the matter is the going to be settled, will approve a settlement. If at some point the other party violates

or breaches one or more terms of the settlement agreement -- and that could be because they don't file the necessary reports or they file them late or change the terms of the settlement; those are some of the 10:28:13 types of violations that we see. Rather than bringing the violation discussion back to the full Board, we are seeking another way to resolve these settlement agreement violations. This is a request that the Board chair and/or vice chair be allowed to decide how to 10:28:31 resolve settlement agreement violations.

CHAIRPERSON OLSON: So do the Board members have questions, or do you want to have some discussion about that proposal? Do you understand what we're asking?

10:28:49 (No response.)

CHAIRPERSON OLSON: So if we were to proceed with that, I would need a motion from the Board to allow the Board chair or vice chair to decide how to resolve settlement agreement violations.

10:29:00 MEMBER BRADLEY: I so move.

MEMBER DEMUZIO: Second.

MR. ROATE: Motion made by Mr. Bradley, seconded by Senator Demuzio.

Mr. Bradley.

MEMBER BRADLEY: Yes.
MR. ROATE: Dr. Burden?
MEMBER BURDEN: Yes.
MR. ROATE: Senator Demuzio.
10:29:21 MEMBER DEMUZIO: Yes.
MR. ROATE: Mr. Hayes.
MEMBER HAYES: Yes.
MR. ROATE: Madam Chair.
CHAIRPERSON OLSON: Yes.
10:29:26 MR. ROATE: That's five votes in the affirmative.
CHAIRPERSON OLSON: The motion passes.
Items for State Board Action: We have no permit renewal requests; we have no extension requests, 10:29:34 so we will move to exemption requests.
First up we have Passavant Area Hospital in Jacksonville for a change of ownership.
Good morning, gentlemen. Would you please sign in, and once you've signed in the court reporter 10:30:00 will swear you in.
(Three witnesses duly sworn.)
CHAIRPERSON OLSON: Mr. Constantino, State Board staff report, please.
MR. CONSTANTINO: Thank you, Madam

Chairwoman. The applicants, Memorial Health System and Passavant Memorial Area Hospital Association are proposing the affiliation of the Passavant Memorial Area Hospital with Memorial Health System.

10:31:16 There was no public hearing on this application, no opposition. There is no funding involved, no acquisition involved in this transaction. There's no name change, no change in the site, no change in the licensee. The applicants have met all of

10:31:37 your rules.

Thank you, Madam Chairwoman.

CHAIRPERSON OLSON: Thank you, Mike. If the applicant would like to do a presentation -- but in light of the fact that there is no opposition, I would

10:31:47 open it to the Board to questions unless you'd choose to give a presentation.

MR. CURTIS: Madam Chair, we want to be respectful of your time, and we'll just be happy to answer questions.

10:31:56 CHAIRPERSON OLSON: Any questions from the Board?

MEMBER BRADLEY: I think this is a good proposal. It would be good for the hospital and certainly good for the Jacksonville community, but I've

had a question all my life, and this is my chance to ask it. What does Passavant mean?

MR. WYNN: Passavant was originally founded by and is actually named after

10:32:21 Reverend Passavant, who is kind of a Johnny Appleseed of hospitals. He has several hospitals that he opened. I have a nice speech if you'd like to know the whole history.

MEMBER BRADLEY: Not today.

10:32:37 MR. WYNN: But it's the name of Reverend Passavant, the last name.

MEMBER BRADLEY: Thank you.

CHAIRPERSON OLSON: Other questions?

MEMBER BURDEN: Thank you, Madam Chair.

10:32:47 I just want to compliment on the hospital profile where I see charity care approaching 5 percent. That's extremely remarkable, having been here for five years and not seeing many institutions approach that. I imagine with the numbers of Medicare and Medicaid

10:33:07 also being as high as they are, I'm wondering is it just because you wanted to help poor people more than other folks in your business? That's amazing.

MR. WYNN: I'm not sure it's more than anybody else, but our board does have a long reputation

of looking after those that are more unfortunate. We actually have a couple of farms that have been donated to the hospital that the proceeds of that farm go to pay for indigent care. So the whole community is
10:33:42 involved.

MEMBER HAYES: I have a question. Concerning the -- you're going to be signing an affiliation agreement on December 31st of 2013. It is not a merger, per se. In other words, what does
10:34:04 Memorial -- the Memorial part of this is a large hospital association, and what are -- the Memorial Health System. What are they doing for -- what does this affiliation agreement mean? Are they acquiring you or are they only -- are they acquiring your debts
10:34:29 and liabilities or what does it mean? Because it's different from the other hospitals in their system; is that correct?

MR. CURTIS: Thank you. That's a great question.

10:34:41 This is a member substitution so Memorial Health System will be the parent of this organization. It will be one of four hospitals within our health system.

So, yes, we will be responsible for all debt

and liabilities, but the basic issue is with national health care reform requiring communities to partner and work together, we can enhance care coordination, improve access to services in the region, and that's 10:35:04 why our health system is very anxious to affiliate in this community, and we've had tremendous positive support from the community about this proposed affiliation. But it is a member substitution for the area, and Memorial Health Systems parent board will be 10:35:20 the public member of this affiliate.

CHAIRPERSON OLSON: Other questions?

MEMBER DEMUZIO: Yes, I do. I just have one for Mr. Wynn. Are you going to be staying on at Passavant?

10:35:35 MR. WYNN: No. Actually, I'm retiring. I was slated to retire December 31st, but when this came about -- we decided that about two years ago, and when this came about and it looked like we were going do this affiliation, I wanted to stay around until it 10:35:53 was completed, and the Board graciously allowed me to do that. So if you people approve this, I guess you're approving my retirement.

CHAIRPERSON OLSON: No pressure.

MEMBER DEMUZIO: That's why I was asking

because I knew you were somewhere in that area.

And if I do not have a chance to say it, I want to say publicly congratulations on your retirement, and you've done an outstanding job at
10:36:19 Jacksonville. Congratulations.

MR. WYNN: We've appreciated your time as senator, too.

MEMBER DEMUZIO: Thank you.

CHAIRPERSON OLSON: May I have a motion
10:36:28 to approve Exemption E00-14, Passavant Area Hospital?

MEMBER DEMUZIO: Motion.

MEMBER BRADLEY: Second.

MR. ROATE: Motion made by Senator Demuzio, seconded by Mr. Bradley.

10:36:43 Mr. Bradley.

MEMBER BRADLEY: Yes.

MR. ROATE: Dr. Burden?

MEMBER BURDEN: Yes.

MR. ROATE: Senator Demuzio.

10:36:52 MEMBER DEMUZIO: Yes.

MR. ROATE: Mr. Hayes.

MEMBER HAYES: Yes.

MR. ROATE: Chairwoman Olson.

CHAIRPERSON OLSON: Yes.

MR. ROATE: Five votes in the affirmative.

CHAIRPERSON OLSON: Motion passes. I think you can still get a flight to Florida tonight.

10:37:06 MR. WYNN: Actually, I'm going to go Mexico.

CHAIRPERSON OLSON: Even better.

The next five items under exemption requests are actually the result of one transaction. So we will

10:37:16 take these all individually, but the applicants can speak to us as one.

That's E-002-14, E-003-14, E-004-14, E-005-14, and E-006-14.

Again, this project had no opposition.

10:38:03 MR. CONSTANTINO: That's correct.

(Two witnesses duly sworn.)

CHAIRPERSON OLSON: Mike, State Board staff report.

MR. CONSTANTINO: Thank you, Madam

10:38:15 Chairwoman.

The applicants have submitted five change of ownership exemption applications for State Board approval. These five exemption applications address one transaction.

The five facilities are Foster G. McGaw Hospital, Gottlieb Memorial Hospital, Loyola University Outpatient Dialysis Center, Loyola University Medical Center Ambulatory Surgical Center, and Mercy Hospital and Medical Center.

10:38:40

There will be no change in the licensee or change in the ownerships of the sites. There was no -- the transaction had no cost. There was no public hearing, and there was no opposition.

10:38:56

Thank you, Madam Chairwoman.

CHAIRPERSON OLSON: Thank you. Again, I will offer to you the same -- if you'd like to leave it open to the Board for questions or if you have any presentation.

10:39:02

MS. HAGERTY: First, I want to thank the staff for their assistance in this matter. I waive any presentation and would be available for questions.

CHAIRPERSON OLSON: Thank you.

Any questions from the Board?

10:39:11

MEMBER BRADLEY: I move for approval.

MEMBER DEMUZIO: Second.

CHAIRPERSON OLSON: I have to read this.

May I have a motion to approve E-002-14, Foster G. McGaw Hospital; E-003-14, Gottlieb Memorial

Hospital; E-004-14, Loyola University Outpatient Dialysis Center; E-005-14, Loyola University ASTC; and E-006-14, Mercy Hospital and Medical Center for a merger/change of ownership to Trinity Health Corporation.

10:39:45

MEMBER BRADLEY: So moved.

MEMBER DEMUZIO: Second.

MR. ROATE: Motion made by Mr. Bradley, seconded by Senator Demuzio.

10:39:54 Mr. Bradley?

MEMBER BRADLEY: Yes.

MR. ROATE: Dr. Burden.

MEMBER BURDEN: Yes.

MR. ROATE: Senator Demuzio.

10:40:04

MEMBER DEMUZIO: Yes.

MR. ROATE: Mr. Hayes?

MEMBER HAYES: Yes.

MR. ROATE: Chairwoman Olson.

CHAIRPERSON OLSON: Yes.

10:40:13

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

CHAIRPERSON OLSON: Motion passes.

MEMBER BURDEN: This is not intended to represent anything regarding this applicant, but I am

going to comment on the report that Loyola University's renal -- end stage renal disease treatment center made as a part of their application, and I feel that our Board has had many discussions about this entity. It
10:40:35 doesn't reflect specifically on anything other than my interest in the report.

Having been on this Board for five years, I've yet to see any report from an end stage renal disease applicant that demonstrates anything close to
10:40:51 the amount of information we have received on this. And this is mostly for Board understanding and hopeful eventual board recognition that this is the kind of report that I personally feel we should have received and would love to receive, in my judgment, regarding
10:41:10 approvals of subsequent applications in the renal disease applications specifically.

I compliment the University in presenting, as far as I'm concerned, an excellent report about what happened during the year of 2012 regarding all the
10:41:22 patients they cover, treat in their facility. That's the only thing I found on this that I have seen that's comparable -- there's nothing comparable in terms of reports, as far as I'm concerned, that's as good as this one.

CHAIRPERSON OLSON: Thank you. Apparently, that's the first time we're collecting that report. So hopefully we'll see many more that are equally as impressive.

10:41:45 MR. CONSTANTINO: Madam Chairwoman?

CHAIRPERSON OLSON: Yes.

MR. CONSTANTINO: That report is the work of Nelson and Mike Mitchell on the staff of the Illinois Department of -- well, Nelson is on the staff

10:41:53 of the State Board, and Mike Mitchell is on the staff of the Illinois Department of Public Health.

We only collect this report on existing facilities. So when you have a new facility, you won't see this. I just want to make it clear.

10:42:05 CHAIRPERSON OLSON: Thank you.

MEMBER BURDEN: My comments are directed to that topic and I appreciate it immensely. But we do have change of locations; we have existing facilities. I commonly asked for this -- and I don't want to delay

10:42:18 this beyond the time frame unnecessarily, but I personally felt this was -- in an area where there's significant change in reimbursement rates for all medical care and more specifically in end stage renal disease which has come close to what I call socialized

medicine ever since 1992.

So I find this information very helpful for me personally as a retired urologist recognizing that there will be new applicants who will not have this
10:42:51 information. And I submit -- this has to be approved. I'm just one lonely solitary voice on this nine-member Board -- we're absent four members -- most of whom commented to me over the past several years we ought to have a seminar on how to evaluate these entities. This
10:43:09 comes close to helping us evaluate movement within the field, and I congratulate those involved, even you, Mr. Constantino.

MR. CONSTANTINO: Oh, I'm just happy you said we did a good job. That's not usually the case.

10:43:24 CHAIRPERSON OLSON: Let's move on.

The next order of business is Alteration Requests and there are none.

The next order of business is Declaratory Rulings or Other Business. First is Hinsdale Surgical
10:43:36 Center in Hinsdale is going to correct their 2012 ASTC profile. We're going to correct their 2012 ASTC profile information.

Do we have a representative? Please sign in and be sworn in by the court reporter.

(One witness duly sworn.)

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

MR. CONSTANTINO: Thank you, Madam Chairwoman.

10:44:20 The State Board staff is requesting a declaratory ruling to revise calendar year 2012 ASTC questionnaire data for Hinsdale Surgical Center in Hinsdale. The State Board staff notes there are no 10:44:34 findings related to declaratory rulings presented to the State Board.

Thank you, Madam Chairwoman.

CHAIRPERSON OLSON: Do you have comments?

10:44:48 MR. DE VRIES: I do not. Only to express my appreciation to Mike for his assistance. I am new to this position, and, therefore, there was some confusion on my part in filing the report, but staff -- particularly Mike has been very helpful to me in 10:45:02 getting oriented to this process.

CHAIRPERSON OLSON: Thank you. He's a helpful guy.

May I have a motion to approve the declaratory ruling Hinsdale Surgical Center to correct

the ASTC data for 2012?

MEMBER DEMUZIO: Motion.

MEMBER HAYES: Second.

MR. ROATE: Motion made by Senator
10:45:21 Demuzio, seconded by Mr. Hayes.

Mr. Bradley.

MEMBER BRADLEY: Yes.

MR. ROATE: Dr. Burden?

MEMBER BURDEN: Yes.

10:45:30 MR. ROATE: Senator Demuzio.

MEMBER DEMUZIO: Yes.

MR. ROATE: Mr. Hayes?

MEMBER HAYES: Yes.

MR. ROATE: Chairwoman Olson.

10:45:38 CHAIRPERSON OLSON: Yes.

MR. ROATE: Five votes in the affirmative.

CHAIRPERSON OLSON: Thank you.

MR. DE VRIES: Thank you very much.

10:45:41 CHAIRPERSON OLSON: Next is St. Elizabeth Hospital, Belleville, to correct a 2006 through 2012 hospital profile information.

(One witness duly sworn.)

CHAIRPERSON OLSON: Mike, State Board

staff report.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The State Board staff is requesting that the 10:46:24 State Board revise calendar year 2006 through calendar year 2012 annual hospital questionnaire data for St. Elizabeth Hospital in Belleville, Illinois.

Again, I remind the Board the State Board staff notes there are no findings related to the 10:46:41 declaratory rulings presented to the State Board.

Thank you, Madam Chairwoman.

CHAIRPERSON OLSON: Thank you, Mike.

Do you have comments?

MS. BALLANCE: None, other than we'd 10:46:52 like to thank the staff for their work and offer to answer any questions.

CHAIRPERSON OLSON: So you found that your report was off from the years 2006 through 2012?

MS. BALLANCE: We did. We went as far 10:47:03 back we felt comfortable we still had good data to do the review, which is why we stopped in 2006.

CHAIRPERSON OLSON: Other questions from the Board?

(No response.)

CHAIRPERSON OLSON: There being none, I would entertain a motion to approve the declaratory rulings for St. Elizabeth Hospital to correct hospital data submitted for years 2006, '07, '08, '09, '10, '11 and '12.

10:47:28

MEMBER HAYES: So moved.

MEMBER BURDEN: Second.

MR. ROATE: Motion made by Mr. Hayes, seconded by Dr. Burden.

Mr. Bradley?

10:47:37

MEMBER BRADLEY: Yes.

MR. ROATE: Dr. Burden.

MEMBER BURDEN: Yes.

MR. ROATE: Senator Demuzio.

MEMBER DEMUZIO: Yes.

10:47:45

MR. ROATE: Mr. Hayes.

MEMBER HAYES: Yes.

MR. ROATE: Chairwoman Olson.

CHAIRPERSON OLSON: Yes.

MR. ROATE: Five votes in the affirmative.

10:47:51

CHAIRPERSON OLSON: For Health Care Worker Self-Referral Act there's no business.

Status Reports on Conditional/Contingent

permits, there is none.

At this point I would like to propose a 10-minute break. It is 10 minutes to 11:00. We will reconvene promptly at 11:00. Thank you.

10:48:10 (Recess taken, 10:48 a.m. to 11:01 a.m.)

CHAIRPERSON OLSON: The people can come to the table. It's Memorial Hospital of Carbondale.

I'm going to remind everybody to please put

11:02:44 the mic as close as you can and speak as loud as you can. The court reporter is having some difficulty. And if I'm waving at you, that means you need to speak up.

(Four witnesses duly sworn.)

11:03:34 CHAIRPERSON OLSON: Mike, State Board staff report.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The applicant, Southern Illinois Healthcare

11:03:43 Enterprises, Inc., and Southern Illinois Hospital Services, doing business as Memorial Hospital of Carbondale propose to modernize and expand clinical and nonclinical services at its existing acute care hospital in Carbondale.

The cost of the project is approximately $52.5 million. There was a public hearing held on this project. One person registered their opposition, and that opposition comment was included at the end of this report.

11:04:12

There was one finding regarding the reasonableness of project cost. The applicants exceeded the State Board standard by approximately $33.95 per gross square foot.

11:04:28

Thank you, Madam Chairwoman.

CHAIRPERSON OLSON: Thank you. Comments for the Board?

MR. SCHAEFER: Good morning. I'm Philip Schaefer. I'm vice president of Southern

11:04:37

Illinois Healthcare. With me today are Bart Millstead, who is the administrator at Memorial Hospital Carbondale; Mike Kassar, who is our chief financial officer; and Dan Boeckman, who is director of facilities for our system.

11:04:49

First, Rex Budde, who is our CEO, would have liked to have been here today to make this presentation. Unfortunately, Rex was unable to keep his obligation because his wife recently passed away.

CHAIRPERSON OLSON: Please send our

sympathy.

MR. SCHAEFER: We are pleased to be here today to present this very important project for health care in southern Illinois. Memorial Hospital of
11:05:09 Carbondale is located in Carbondale and provides health care to residents of a large geographic area. The seven counties in our market area have all been designated by the Federal government as health professional shortage areas, while part or all six of
11:05:22 these counties have been designated as medically underserved areas, and the low income population in the southern counties has been designated medically underserved population.

We're in the midst of a successful and
11:05:35 extensive position that so far as enabled us to expand the range of medical services that we provide to the population we're privileged to serve and to permit residents of southern Illinois to receive tertiary care close to home without having to travel to Missouri,
11:05:49 Indiana, and Kentucky. We're here today to seek your approval to expand our hospital so that we may serve these patients in appropriately sized and configured facilities.

First, we thank the staff for their detailed

review of our application and would like to take a few minutes to respond to the only negative finding, the new construction contingency cost per square foot that exceeds the State standard.

11:06:09 As we stated on page 29 of our CON application, this project has a number of factors that have affected the new construction cost. Our construction project manager has estimated that these factors add approximately $37.20 per square foot to the 11:06:24 new construction costs, and I'll summarize those for you.

The first issue is that Memorial Hospital of Carbondale is located on the new Madrid earthquake fault, as a result of which, any new construction and 11:06:36 any modernization to existing facility structures must meet the current seismic codes for buildings. The current seismic codes have unique requirements for buildings that are located in an earthquake area, and construction to meet these codes is more complex in 11:06:50 both foundation and throughout the structure. The cost of meeting the current seismic code has been estimated at $10.25 per square foot in new construction costs for the project.

There are a number of additional factors that

make the new construction more costly. These are as follows:

First, the new construction which consists of two separate additions, one adjacent to the existing
11:07:10 hospital building and one being constructed on top of the existing hospital building, will take place on a restricted site with difficult access for construction equipment, supplies, and workers.

Second, the construction of both these
11:07:23 additions will take place adjacent to and on top of existing hospital departments that must remain in operation during the construction period. One of the new areas of construction will take place adjacent to the emergency department. The other will take place
11:07:36 adjacent to and on top of the surgery suites.

Third, all the new construction will be more complicated than routine new construction on an open site. As I stated, one of the new additions will be constructed on top of the existing hospital building.
11:07:47 In addition, portions of the exterior walls of departments in the existing building must be removed in order to permit construction of the new addition adjacent to the space.

And, finally, we're going to have to demolish

an existing four-story stairwell in order to accommodate construction of a new addition in that location. These additional factors are estimated to have added an additional cost of $29.65 per square foot
11:08:11 to construction of the new space.

As I mentioned, all these factors are estimated to add $37.20 per square foot to the new construction cost. When these extraordinary costs are subtracted from the estimated new construction cost,
11:08:23 the new construction cost per square foot is reduced to $415.20, which is $3 below the State standard of $418.45.

We appreciate the opportunity to be here today, and we'd be happy to answer any questions you
11:08:38 might have.

CHAIRPERSON OLSON: Thank you.

Questions for the Board. Mr. Bradley.

MEMBER BRADLEY: Just a comment. I represented the Board at the hearing in Carbondale, and
11:08:48 I should tell you that the most eloquent spokesman on behalf of this project was a man named Glenn Poshard, who is the president of SIU Carbondale and is also a former chair of this board.

CHAIRPERSON OLSON: John.

MEMBER BURDEN: Can I be heard?

CHAIRPERSON OLSON: Oh, sorry.

MEMBER BURDEN: Thank you, Madam Chair. My inquiries are directed not so much to the
11:09:14 reasonableness of project cost but to the hospital profile in 2012.

Number one, I've been aware about its being a medically underserved community, and with the prior applicants we've seen here, I haven't seen
11:09:35 neurosurgical procedures done, and I notice that you must have acquired a neurosurgeon. On the surgery operating room utilization, I notice 481 neurosurgical procedures lasting 3 1/2 hours.

Is there a neurosurgeon on board?

11:09:54 MR. SCHAEFER: There are two. If you recall back, when we had the medical malpractice crisis in the state, we lost both of our neurosurgeons.

MEMBER BURDEN: I'm well aware. Without going into that, I knew. So I was aware independent of
11:10:08 what I've seen here on this board that you were underserved for sure in an area of critical importance.

MR. SCHAEFER: For that period of time, we had two. We now have three.

MEMBER BURDEN: That's terrific. I'm

happy about that for sure for you and for your community.

And I'll check out something else that I think obviously is coming. Your peak hospital admissions seems to me you're running pretty fully. I haven't asked about med/surge occupancy, but I think you must be anticipating that shell space getting back pretty soon, I would think --

11:10:29

MR. SCHAEFER: One of the reasons --

11:10:41

MEMBER BURDEN: -- as soon as you get some money together to try and expand your med/surge occupancy.

MR. SCHAEFER: Sorry. I didn't mean to interrupt.

11:10:46

MEMBER BURDEN: No, that's fine.

MR. SCHAEFER: One of the reasons we've been successful financially with our payer mix -- and we're very strongly Medicare and Medicare and self-pay -- is that we've been very conservative and

11:10:57

have operated high in the occupancy curve. That's allowed us to be as efficient as we think we can possibly get.

We think that health care reform going forward is going to have some influence in inpatient

use rates. We like that stuff.

MEMBER BURDEN: You think? Let me say -- and I can speak from prior experience because I'm much older than you -- I know.

11:11:18 MR. SCHAEFER: I know you all read Crane's, and you see where have all the inpatients gone. We have taken a conservative approach to shell space. If indeed patient rates were to drop and stay low, we're positioned for that. However, if they were

11:11:31 to rise back up or continue to grow or our physicians we recruited increase our utilization, then we'll come back and ask you to finish out that space.

MEMBER BURDEN: Thank you very much.

MR. SCHAEFER: Thank you.

11:11:42 CHAIRPERSON OLSON: I just want to say I think that's the finest explanation for reasonable project cost I've ever heard and I appreciate that.

MR. SCHAEFER: Thank you.

CHAIRPERSON OLSON: Mr. Hayes.

11:11:54 MEMBER HAYES: Thank you, Madam Chair. I wanted to discuss the opposition letter here. And it's from the Marion Healthcare, LLC. Could you address -- basically, they talked about the modernization and expansion of the surgical suite

including the increase of three general multispecialty operating rooms. And then they talk about the Blue Cross and Blue Shield exclusivity contract that you have with them.

11:12:27 Could you comment on that?

MR. SCHAEFER: Not really an exclusivity contract. Out of the 10 hospitals in our region, all 10 hospitals have Blue Cross/Blue Shield contracts. Out of the six surgery centers, five of the six have

11:12:44 contracts with Blue Cross/Blue Shield, as well. The opposition does not have a contract with Blue Cross/Blue Shield.

In terms of utilization and the appropriateness of the size, we can justify the

11:12:56 additional ORs based on our volumes today. In fact, we can justify more ORs than we have asked for. We've been conservative in that regard, as well.

So I think the opposition -- I can't really speak for their motivation in writing the letter, but I

11:13:05 would suspect that they're also seeing decrease in utilization with health care reform and that type of thing going on.

The fact of the matter is, though, that we don't really take care of all the same type of cases.

A big part of our utilization is total joints, major orthopedic work, cardiovascular, neurosurgical, and they're not doing quite those cases. They're doing more ambulatory cases.

11:13:28 So it's a bit of an apples and oranges comparison, but primarily I suspect that they're opposing because they would like to see more utilization.

MEMBER HAYES: So what you're saying is

11:13:37 that you're not open to be able to basically forego those three surgical suites in your project?

MR. SCHAEFER: They're essential. We actually I think could make a strong case for more, but we've come in with a conservative approach given the

11:13:54 current volume that we have and what we think our new physicians are going to bring to us and are currently starting to grow into.

MEMBER HAYES: Now, you said that the exclusivity contract with the Blue Cross/Blue Shield,

11:14:07 you've mentioned that the hospitals -- how many are there, six or seven in the area?

MR. SCHAEFER: There are 10.

MEMBER HAYES: 10 that have this Blue Cross/Blue Shield --

MR. SCHAEFER: All 10.

MEMBER HAYES: -- contract, and then five of the six surgery centers.

MR. SCHAEFER: Right.

11:14:18 MEMBER HAYES: But this -- it's important somebody very close to you, this Marion Healthcare, LLC, does not. Is that correct?

MR. SCHAEFER: That's my understanding. We're a little bit different than Marion

11:14:30 Healthcare, as well. As you'll notice from the annual reports, we care for a fair amount of charity care. They do not. And that's not to say that they're bad or we're good, but we just serve different populations.

MEMBER HAYES: Now, the Blue Cross/Blue

11:14:49 Shield contracts with the other -- you may not know this, but are patients able to get similar types of services at those other 10 hospitals and five ASTCs?

MR. SCHAEFER: Well, let me clarify your question if I might, please.

11:15:05 MEMBER HAYES: Okay.

MR. SCHAEFER: Similar types of services -- we're a tertiary provider for our region. So some of the hospitals, critical access hospitals don't have the same medical staff or the capabilities

that we do. Do they have the same access to care for the same types of things that we do? I believe they do, yes.

MEMBER HAYES: And is your cost similar to them, your cost structure?

11:15:24

MR. KASSAR: Our cost structure compared to a surgical center is always going to be higher. A hospital has an emergency room, neonatal intensive care unit, other services that we need to provide that have higher costs. So our costs spread over all of our services are going to be higher.

11:15:49

Whether that is a higher cost to the payers, both the insurance companies and the patients, I don't know because I don't know what others contracts are. I do know that Blue Cross and the other major payers in the area are very happy to contract with us on an arm's-length basis, which I think means that we are cost effective when compared to the other providers in the area.

11:16:08

MEMBER HAYES: Okay. In this opposition letter they talk extensively about their costs are, you know, maybe half of or even 30 to 50 percent less. Do you have any comment on that?

11:16:26

MR. SCHAEFER: Well, I think that the

analysis presented there did not present the whole picture. Can we cite cases where our costs might be more because of a patient's care required, the medications they required, the antibiotics, the length 11:17:03 of the surgical procedure, that type of thing? I'm sure that we could probably make a case in the other direction.

I would tell you that in comparison with other hospitals in our region we're very competitively 11:17:12 priced. In terms of surgery centers, I think the surgery centers are always going to be a little bit less expensive than a full-service hospital.

MEMBER HAYES: Well, I compliment you on the extent of your services, and you're very important 11:17:25 for that southern Illinois region there, and the obstetrics and gynecology area -- you have 28 beds now? You have 28 beds.

MR. MILLSTEAD: We have 28 beds in obstetrics.

11:17:44 MEMBER HAYES: Most of the time the smaller hospitals in these areas are eliminating that service it seems like, so I think it is very important that you provide those services. So I wanted to compliment you on that.

MR. SCHAEFER: Thank you. Last time we looked we deliver more babies than anybody in the south half of the state. Mothers tend to come to us. We have a Level II-plus nursery to care for the children, as well, so they don't have to go to St. Louis.

11:18:07

It's a privilege to do what we do. We're very grateful to be able to care for the people that we live with.

MEMBER HAYES: Well, thank you.

11:18:20 CHAIRPERSON OLSON: Other questions from the Board?

(No response.)

CHAIRPERSON OLSON: May I have a motion to Project 13-069, Memorial Hospital of Carbondale, for

11:18:25 a major modernization expansion project at its hospital in Carbondale?

MEMBER BRADLEY: So moved.

MEMBER BURDEN: Second.

MR. ROATE: Motion made by Mr. Bradley,

11:18:37 seconded by Dr. Burden.

Mr. Bradley.

MEMBER BRADLEY: Yes.

MR. ROATE: Dr. Burden.

MEMBER BURDEN: Yes. And I want to

compliment -- I'm sure your CEO, who it is unfortunate he is suffering from a loss, should know -- I've heard a lot of presentations; this comes from the gut -- thank you very much for the way you handled this.

11:19:00 MR. SCHAEFER: Thank you.

MR. ROATE: Senator Demuzio.

MEMBER DEMUZIO: Yes.

MR. ROATE: Mr. Hayes?

MEMBER HAYES: Yes.

11:19:11 MR. ROATE: Chairman Olson.

CHAIRPERSON OLSON: Yes.

MR. ROATE: Five votes in the affirmative.

CHAIRPERSON OLSON: Motion passes.

11:19:20 Thank you very much.

Next we have DaVita Belvidere Dialysis in Belvidere. Please sign in and be sworn in.

(Four witnesses duly sworn.)

CHAIRPERSON OLSON: State Board staff

11:20:14 report.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The applicants are proposing to establish a 12-station ESRD facility in Belvidere, Illinois. The

cost of the project is approximately $2.8 million. There was no public hearing, no letters of opposition.

There were two findings. Planning area need, there was a calculated access of 16 ESRD stations, and

11:20:39 then there was unnecessary duplication of service. Two of the four facilities within 30 minutes are not operating at the target occupancy of 80 percent.

Thank you, Madam Chairwoman.

CHAIRPERSON OLSON: Thank you, Mike.

11:20:53 Presentation to the Board.

MR. SHEETS: Good morning, Madam Chairman, members of the Board, staff. Chuck Sheets from Polsinelli, I'm the attorney on the project. I have with me to my left Mary Anderson, who is the

11:21:06 divisional vice president for DaVita. I have Dr. Ahmad to her left, who is from Rockford Nephrology Associates, as well as medical director for the dialysis facility, and then to his left I have Anne Cooper also from my office.

11:21:21 I'd like to introduce you to our vice president of operations, Mary Anderson.

MS. ANDERSON: Good morning and thank you for this opportunity to provide the Board with some background on this project.

The proposed Belvidere Dialysis is desperately needed to improve access to much-needed dialysis services in Belvidere and to alleviate the overutilization of existing facilities in Rockford.

11:21:46 Belvidere is located approximately 13 miles or 25 minutes due east of Rockford. Dr. Ahmad's group, Rockford Nephrology Associates, currently treats 35 ESRD patients that reside in Belvidere but dialysize in Rockford.

11:22:03 Additionally Rockford Nephrology Associates are treating 102 pre-ESRD patients. 57 of those are in Belvidere alone. Based upon attrition due to patient death, transplant, returned function in these three locations, Dr. Ahmad projects 34 of these Belvidere

11:22:23 pre-ESRD patients will initiate dialysis within the next 12 to 24 months. Importantly this data demonstrates that there is sufficient patient base within Belvidere to justify the establishment of the proposed Belvidere Dialysis.

11:22:37 As I previously mentioned, there is currently no dialysis facility in Belvidere. As a result, patients travel to one of our four facilities in Rockford. All of these facilities are highly utilized. Rockford Dialysis is at 110 percent utilization and

operates a fourth shift. Stonecrest and Roxbury Dialysis operate at 97 percent and 87 percent respectively. Churchview is currently at 78 percent with two pending add-ins this week, which will put it
11:23:13 at 79 percent. We expect to reach 88 percent at Churchview by June.

Due to the high utilization of these facilities, patients under dialysis are often scheduled for the third or, in the case of our Rockford clinic,
11:23:29 fourth shift until an earlier shift becomes available. While we do our best to accommodate our patient's needs and preferences, the wait for first and second shifts can be well over a year.

Patients dialyzing often arrive and leave the
11:23:44 dialysis facility in the dark. Many patients are elderly, suffer multiple comorbidities and/or rely on assistive devices. While some safety hazards cannot be avoided during the winter or during inclement weather, they are more comfortable when they can come and go
11:24:00 during daylight hours. Further, transportation issues are more complicated, as you heard from our transportation system Keen Age.

Patients live in rural areas, and there are many barriers found that are not found in larger open

areas, particularly when traveling to neighboring counties for medical facilities. There is no public transportation between Belvidere and Rockford. Keen Age is operated by the Boone County Council on
11:24:29 Aging. It is the only transportation company that will transport patients from Belvidere to Rockford. However, it only operates during normal business hours and only provides group transports.

What this means is Belvidere patients who
11:24:43 utilize Keen Age can only dialyze on the second shift. Additionally, these patients must all arrive and depart as groups. If one patient is running late, all of the other patients will be late for their dialysis. When a patient has an issue -- for example, if they're
11:25:01 bleeding, or they're dizzy, or they have nausea -- they cannot be discharged from our facility, and they must wait until they're stable. That means the rest of the patients must also wait, and as a result, these patients can be up at the facility for up to seven hours.

11:25:16 While many patients utilize Keen Age, other patients are relying on friends and family members to transport them to and from their dialysis and this creates its own issues.

Transportation becomes even more difficult

during periods of inclement weather when travel is treacherous. Unlike schools, government offices, and even this Board, when the weather is poor, businesses close. Unfortunately, our patients still have to come
11:25:43 to treatment. Many of them end up missing treatment because the bus does not travel on days of inclement weather. That results in a hospitalization rate for them and also increased mortality.

A new facility in Belvidere will alleviate
11:26:05 overutilization at the Rockford area facilities, improve access, and minimize the hardship on patients and their caregivers. We respectfully request the Board to approve our application to establish this clinic.

Thank you.

11:26:19 CHAIRPERSON OLSON: Thank you.

Questions from the Board?

MEMBER BURDEN: Thank you, Madam Chair.

It obviously appears to me the Belvidere facility will enable a Rockford patient to have more
11:26:35 ready access and take some of the load from the overutilized areas at Stonecrest and Roxbury. My question really is directed to Marengo and when DaVita purchase the Marengo facility? It says "recently." When was that?

MS. ANDERSON: That was December 1st.
MEMBER BURDEN: Just a couple months ago.
MS. ANDERSON: 2013.
MEMBER BURDEN: What's going to happen
11:27:00 to Marengo with Belvidere being halfway between Rockford and Marengo.
MS. ANDERSON: The Marengo clinic does not service any Belvidere patients. Although it's close, it's all rural travel. They're country roads
11:27:15 and it is easier for our patients to get -- in Belvidere, that live in Belvidere to get to Rockford because it's a four-lane highway, but in Marengo it's all rural roads.
MEMBER BURDEN: What you're saying is if
11:27:30 it's a rural area, those folks who are traveling from rural communities -- having grown up in one, I know that in the wintertime. However, I still question what's happens to that facility? Are you going to be back in a year asking to go close down the Marengo
11:27:46 facility?
MS. ANDERSON: Oh, absolutely not. We service --
MEMBER BURDEN: Do you anticipate it ever getting to the acceptable range, or is it going to

remain underutilized? That's my question.

MS. ANDERSON: I do project that it will. Our census does fluctuate there because of the area that it's in because of it being so rural. But 11:28:03 yes, we have been up to almost 80 percent.

MEMBER BURDEN: That facility has been up to 80 percent at one time.

MS. ANDERSON: In the past under the previous owners, yes.

11:28:14 MEMBER BURDEN: Well, the Belvidere facility is not going to help it. I recognize the need for what you're presenting, but I'm recognizing also that that facility seems to stand alone and be struggling.

11:28:30 MR. SHEETS: Dr. Burden, if you look at the last page of the State Agency report, there's a map. And I know you're kind of familiar with this area, but you can see that Marengo is quite a bit east of Belvidere, and from looking at it, it looks like a 11:28:46 third farther than Rockford. Plus, plug in the fact that Marengo is off of the highway on rural roads. It just makes it more difficult for patients in Belvidere to get to that point.

I understand that doesn't really speak to the

Marengo utilization, but Marengo -- we're confident that we'll get it up to that proper utilization, but it won't be from patients in the Belvidere area. So, unfortunately, it doesn't work. They don't go
11:29:18 that way.

MEMBER BURDEN: Thank you.

MS. ANDERSON: They don't. It is in a different HSA area.

MEMBER BURDEN: Pardon me?

11:29:25 MS. ANDERSON: The Marengo clinic is in a different HS area than the Rockford clinics and Belvidere.

MS. COOPER: The other thing I want to mention to you about Marengo is it's a different
11:29:40 county. So those patients who are relying on public transportation -- for example, the Boone County Area Transit that actually transports patients from Belvidere to Rockford, they can't transport patients to Marengo because it's in a different county. So it
11:29:54 would be harder for them to access that facility.

MEMBER BURDEN: I just see and read some of the information regarding the two largest -- in my era DaVita was just a blip on the sonar. In 15 years it's all changed. But I get the information

independently from this board showing me that the large organizations are trimming their staffs. I think this is in anticipation of what's coming with quote/unquote the Affordable Care Act. Employees -- this came in
11:30:31 some circular I read not too long ago, I don't know.

Makes me wonder down the line just how many more units are going to be necessary in terms of utilization. Utilization has got to be higher. If I'm dead wrong, I'm not in the business, you guys are, but
11:30:53 I don't see them building a lot more until we see a more effective response to the so-called Affordable Care Act and what's happens in that area.

This has been socialized medicine since 1992. It's been floating real well, but I see change coming
11:31:09 on the horizon. That's all. You've got a facility at 50 percent. You're building another one that you don't think is going to have an impact on it. I question that.

CHAIRPERSON OLSON: Maybe I can help
11:31:21 answer that a little bit, being in health care in the Rockford area for a period of time, and I think that some of the other people here can attest to this. People in Belvidere will not go to Marengo, and there is huge transportation issues. They don't even want to

come to Rockford to get health care.

It's kind of a very interesting dynamic, and I can't explain it other than to say it exists, and I think other people in the room would say that, as well.

11:31:45 With the transportation option, they can't get -- if you've ever driven from Belvidere to Marengo, I'm sure there were almost as many days this winter that you couldn't get there as you could get there.

I understand it's in the 30-mile radius, but

11:32:01 this is an extremely rural area, and there's just no way for those people to get to Marengo.

MS. ANDERSON: It's hard to explain it, but we have no patients at the Marengo clinic from Belvidere at all.

11:32:17 CHAIRPERSON OLSON: Other questions?

MEMBER HAYES: Thank you, Madam Chair. Aren't Marengo and Belvidere as close to I-90?

MS. ANDERSON: Marengo?

MR. SHEETS: If you look at the last

11:32:32 page, you can see it's probably 7 or 8 miles from I-90.

MEMBER HAYES: Marengo has recently in the last couple of years gotten a big exit and exchange there; is that correct? They have built that on I-90?

MR. SHEETS: Route 23 maybe? I'm

guessing. I don't know.

MS. ANDERSON: Belvidere to Marengo it's all rural roads.

MR. URSO: We can't hear you.

11:33:06 MS. ANDERSON: Oh, I'm sorry. When I travel from Marengo to Belvidere or vice versa, it's all rural roads.

MEMBER HAYES: Why couldn't -- from Belvidere how far is it to I-90 from there?

11:33:27 CHAIRPERSON OLSON: Going 20; right?

MR. SHEETS: Lake Street there, Route 20 -- I don't think it's called Lake Street there. I'm showing where I'm from. Anyway, it goes right through Marengo, and it's sort of a main state

11:33:42 road there. That's probably why people take -- it's more direct, Mr. Hayes. It's not that you couldn't get there from I-90, although I don't know that there's an exit there. It sounds like there might be.

DR. AHMAT: I-90 from Rockford to

11:34:00 Marengo, about 30 minutes.

MEMBER HAYES: Now, is there a possibility of going into the Wisconsin area, southern Wisconsin for these patients up Route 39?

MS. ANDERSON: There is a dialysis unit

in Beloit. It's owned by Beloit Memorial.

MR. SHEETS: But that's outside of the 30-minute drive time.

MEMBER HAYES: But Roscoe is very near there; is that correct?

11:34:40

MR. SHEETS: I'm not sure, Mr. Hayes, but there is -- in the body of the Agency report there is a 30-minute drive time. There's only four facilities in a 30-minute drive time of Belvidere.

11:35:00

MEMBER HAYES: Well, the Beloit Memorial Hospital would not be in the report even if it was. I don't think we look at Wisconsin dialysis centers.

Is that correct, Mike?

MR. CONSTANTINO: That's correct.

11:35:15

CHAIRPERSON OLSON: Beloit is more than 30 minutes.

MR. SHEETS: Right.

MEMBER HAYES: But they're going right up 39, a pretty good road, and you're going right past

11:35:25

Roscoe.

MR. SHEETS: You're correct. There is a highway directly north up to Beloit, but it is quite a ways.

MEMBER HAYES: Okay. Thank you.

CHAIRPERSON OLSON: Other questions or comments?

(No response.)

CHAIRPERSON OLSON: May I have a motion 11:35:41 to approve Project 13-070, DaVita Belvidere Dialysis to establish a 12-station facility in Belvidere?

MEMBER BURDEN: So moved.

MEMBER BRADLEY: Second.

MR. ROATE: Motion made by Dr. Burden, 11:36:00 seconded by Mr. Bradley.

Mr. Bradley.

MEMBER BRADLEY: The applicants have met 11 -- 10 of our criteria, and I think the need for access in this town overrides the two criteria that 11:36:16 they did not meet, so I vote yes.

MR. ROATE: Thank you.

Dr. Burden.

MEMBER BURDEN: I recognize the need in the Belvidere community both from the application and 11:36:29 the public participation aspect. I reserve some reservation about how Marengo will remain open, but I'm going to vote yes on this.

MR. ROATE: Senator Demuzio.

MEMBER DEMUZIO: Yes. For the previous

statements mentioned.

MR. ROATE: Thank you, ma'am.

Mr. Hayes.

MEMBER HAYES: I'm going to vote yes

11:36:54 because of the issue of transportation for the patients in Belvidere and that -- this is being able to override the two criteria, planning area need, and unnecessary duplication of services that were in the State Agency report. So I'm going to vote yes.

11:37:19 MR. ROATE: Thank you.

Chairman Olson.

CHAIRPERSON OLSON: I also vote yes for the reasons just stated.

MR. ROATE: Five votes in the affirmative.

11:37:29 CHAIRPERSON OLSON: Motion passes. Thank you.

MR. SHEETS: Thank you very much.

Central DuPage Hospital in Winfield is up next.

11:38:14 (Four witnesses duly sworn.)

CHAIRPERSON OLSON: State board staff report, Mike.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The applicants are proposing to add 33 acute mental illness beds to the acute mental illness category of service for a total of 48 AMI beds at its existing acute care hospital.

11:38:34 The cost of the project is approximately $20.4 million. The applicants addressed 11 criteria and failed to meet one, the size of the project. The applicants exceeded the State Board standard by 128 departmental gross square foot. There was no

11:38:53 public hearing and no letters of opposition received by the State Board staff.

Thank you.

CHAIRPERSON OLSON: Thank you.

Presentation or comments to the Board.

11:39:02 MR. LEMON: Yes, thank you. Good morning, Madam Chairman and members of the Board. My name is Brian Lemon. I'm the president of Central DuPage Hospital and executive vice president of Cadence Health, which is the system that we're part of.

11:39:12 Joining me at the table are Dr. Danesh Alam, who is the medical director of our behavioral health programs at CDH; Honey Skinner, our CON counsel; and Jack Axel, our CON consultant. And I thank you for the opportunity to address you this morning.

Our community is in crisis because of a lack of reasonably accessible acute mental illness beds. The situation is particularly alarming within our adolescent population where our schools and parents are
11:39:38 clamoring for in-community mental health services to address the growing number of young people in need.

The projects we are bringing before you address that crisis head on. We are proposing to expand on our commitment to inpatient acute mental
11:39:56 illness care, including a unit dedicated to the care of adolescents.

We're currently operating a 15-bed AMI unit that accepts all age groups adolescents through adults. Every year since 2007 that unit has operated at
11:40:09 100 percent capacity, and it is not unusual for us to overflow onto a medical unit. In addition, during the 12-month period ending August 31st, 2013, our emergency department was forced to arrange transfers to other hospitals for 564 patients requiring immediate
11:40:28 admission to an AMI bed. Our sister hospital, Delnor Hospital, needed to find beds for 95 patients elsewhere during that period. This transportation elsewhere, most of whom are patients of our physicians, eliminates the ability of these patients' physicians to follow

their care and unnecessarily compromises the patient's continuity of care.

Our proposed project will allow us do something that we have not been able do before. We'll 11:40:56 be providing three separate age-group-specific units. Our existing AMI unit on the first floor of our center building will operate as an adolescent unit. A unit will be developed on the third floor of that building, 3 Center, to address the needs of older adults and 11:41:14 higher acuity patients, and the third unit will be developed on 5 Center for lower acuity adults. The third and fifth floor space to be used is now vacant.

This project has not been opposed by any other area provider nor has any other opposition to the 11:41:30 project been voiced. We appreciate the support that we received from organizations and agencies such as the DuPage Health Coalition, Access DuPage, Metropolitan Family Services, and the DuPage County Health Department. We've also had very positive discussions 11:41:45 with a number of the area school districts which are supportive of our plans and often mentioned increasing incidence of mental illness within their student populations.

As I trust you've noted, this project has

been developed consistent with all of your review criteria that we have any control over. We have worked hard to develop our reputation as the go-to hospital in our area. At the same time and as referenced in the
11:42:11 support letter from Dick Endress of the DuPage Health Coalition, we've been the largest direct funder of Access DuPage since 2001, and we've provided over half the hospital services received by Access DuPage members. Access DuPage's mission is to provide a safety net of
11:42:28 health care services for the low income residents of DuPage County. Our commitment to Access DuPage includes our existing mental health services and will most certainly carry over to our proposed expanded role.

Finally, our proposed project has been
11:42:44 developed consistent with each of the Board's review criteria except one, that being criterion 11-10-234(a) addressing the square footage per bed. As discussed in the alternatives narrative, we elected to expand our AMI services through the reuse of existing areas
11:43:03 originally used as med/surg units rather than through new construction. The square footage that we are allocating to our AMI services is a result of the configuration of the available space we have.

Thank you for your attention, and we'd be

happy to answer any questions that you may have.

CHAIRPERSON OLSON: Thank you.

Questions from the Board?

Dr. Burden.

11:43:19 MEMBER BURDEN: Thank you, Madam Chair.

This can't be unique to your community the increase in adolescent issues requiring hospitalization. I address this to the psychiatrist as much as anybody. In an affluent community which is 86 percent

11:43:40 Caucasian -- access to drugs? What is it that has suddenly become such an emerging problem unique to your community? Which I wonder, is it unique to your community. That's my question.

DR. ALAM: I don't think it's unique to

11:43:59 our community? I think what is unique is to see such a problem in our community. For example, the Naperville schools are in a state of crisis from the perspective of heroin use. In fact, we came -- on the street for Naperville North, where I would love my kids to go to

11:44:20 that school district, the word on the street is it's called Naperville North Heroin High School. It's sad. It's a tragedy. I think -- I hope it has nothing to do with the recent arrests. I mean, Chicago was the center of heroin trafficing for the country.

We are probably the only program, I want to say I probably can make a claim in the Chicago area that provides residential substance abuse services. We have 20 beds where we actually accept all payers, 11:44:56 including Medicaid, and we're proud of it. And I think that our addiction services -- I happen to be an addiction psychiatrist, as well -- is actually committed to providing specialized services to our youngsters. In fact, we've established two programs 11:45:14 that we work with our school district as well as for the youth dealing with the substance abuse problems.

MEMBER BURDEN: I appreciate your answer and I suspect part of the reason you're able to render your community is because of the success that Central 11:45:33 DuPage has had. Luke is gone, right, so you're still making a buck out there. So I'm going to ask this next question -- nothing to do with the problems you're presenting today. We've spent a lot of time, so I don't want to take too much time, but proton beam 11:45:49 therapy on your hospital profile says zero.

Burden asks about this proton beam therapy because it was a big one here years back, and I'm sure that the profiler has left out some data. I would assume all the money spent on the proton beam cancer

treatment center has not been gone for naught.

MR. LEMON: No. The proton beam facility is still in operation.

MEMBER BURDEN: It doesn't say so on the
11:46:18 hospital profile of 2012. That's what I'm getting at. That's got nothing to do with why you're here, and I appreciate your answer, Doctor.

CHAIRPERSON OLSON: Other questions?

MEMBER DEMUZIO: I don't have a mic here
11:46:32 but just a quick question. Where do your adolescents go now? Because I'm looking at your DuPage County Health Department letter here, and it seems that you have a fairly large population that's going through there. Where do they go now?

11:46:56 DR. ALAM: It's a great question. It's a daily challenge for us. We're a mixed unit. It is very challenging for our staff to manage adolescents as well as some of our geriatric patients in the same unit. It is hard for me to talk to families from our
11:47:15 community and tell them we don't have rooms for their kids in our hospital.

MEMBER DEMUZIO: That's the question.

DR. ALAM: I also get calls from our ER physicians saying, "What do you mean you can't take

this patient?" It's a daily challenge and I am really proud of our leadership team that has taken the bull by its horns and said we will develop a program.

MEMBER DEMUZIO: So when you get to that
11:47:41 point where you have to tell them that you do not have a bed available -- we saw happened to the congressman where that same issue happened where they went home that night, and, of course, we know what happened. So we do have that situation here where the beds are not
11:48:00 available and the parents have to take that child home?

DR. AMAT: So very, very sophisticated questions. It's very challenging. So I can't have someone who is a risk in our emergency room, and the choice may be to go to another facility, and maybe we
11:48:20 can put a Plan B into place and send them home. And that's where it's really stressful for us, and it puts pressure on our team when we have to get to a point where we have to make a decision which does not involve inpatient treatment.

11:48:37 MEMBER DEMUZIO: So as soon as they walk out the door, then that responsibility comes back on you --

DR. AMAT: Absolutely.

MEMBER DEMUZIO: -- should something

happen to that child?

DR. ALAM: Absolutely. So, also, I think our emergency psychiatric services team, they have become experts at finding beds. We have a list of 11:48:59 48 hospitals that we work with. So we send patients routinely to Rockford or Kankakee or up in Lake Zurich and other areas. So it's very challenging and we have staff that just do that, find beds.

MEMBER DEMUZIO: Thank you. I 11:49:15 appreciate your answer.

CHAIRPERSON OLSON: Other questions?

(No response.)

CHAIRPERSON OLSON: Seeing none, may I have a motion to approve Project 13-071, Central DuPage 11:49:23 Hospital for major modernization project in Winfield?

MEMBER BRADLEY: So moved.

MEMBER BURDEN: Second.

MR. ROATE: Motion made by Mr. Bradley, seconded by Dr. Burden.

11:49:33 Mr. Bradley.

MEMBER BRADLEY: This project has overwhelmingly met our criteria under which they were reviewed. I think it's clear that there is a crisis in our society today. I hear it from people at many other

hospitals, as well, and since it is, I believe partly because of an abdication of the State's responsibility over time, I'm delighted to see these people stepping up and I vote yes.

11:50:05 MR. ROATE: Thank you.

Dr. Burden.

MEMBER BURDEN: I obviously vote yes. I think there's a need and appreciate the applicant's explanation to my questions. I vote yes.

11:50:19 MR. ROATE: Senator Demuzio.

MEMBER DEMUZIO: I vote yes due to the fact that I certainly believe there is a need, and I think at some point you'll be coming back for more beds, unfortunately.

11:50:33 MR. ROATE: Thank you.

Mr. Hayes.

MEMBER HAYES: I'm going to vote yes because of the need, and I think the explanation for the size of the project is reasonable. And they are

11:50:47 using the current facility, so there's no new separate building being constructed. So I'm going to vote yes.

MR. ROATE: Thank you.

Chairman Olson.

CHAIRPERSON OLSON: I vote yes, as well,

and I would really hope that we could get it completed before June 2016. It sounds like we need it now. So hurry up.

MR. LEMON: We'll get going.

11:51:14 MR. ROATE: Five votes in the affirmative.

CHAIRPERSON OLSON: Motion passes. Thank you.

It is five to 12:00. I believe at this point before we take another applicant we'll adjourn for

11:51:29 lunch. We'll reconvene at 12:45. So be back in this room at 12:45. Thank you.

(Recess taken, 11:51 a.m. to 12:47 p.m.)

CHAIRPERSON OLSON: May I have the next

12:47:06 applicant, NorthPointe Health and Wellness Center come to the table, please.

(Seven witnesses duly sworn.)

CHAIRPERSON OLSON: Mike, State Board staff report.

12:48:37 MR. CONSTANTINO: Thank you, Madam Chairwoman.

This applicant, NorthPointe Health and Wellness Campus ASTC, we received two comments on the State Board staff reports. We e-mailed them to the

Board members, and I've distributed copies here this afternoon.

Do we need to take any action on that now?

CHAIRPERSON OLSON: Frank.

12:49:00 MR. URSO: Yes.

CHAIRPERSON OLSON: We need to know if the Board would like to enter these into the application and review the application with these comments or whether we would like to wait until the

12:49:12 comments have been reviewed by our Board staff. We all had them in an e-mail earlier and have had the opportunity to read them, so we just need to make a decision on that.

MR. URSO: And these comments are

12:49:25 timely, and they seem to be responsive to the State Agency reports.

CHAIRPERSON OLSON: Can I have a motion to accept these two documents into the record?

MEMBER BURDEN: So moved.

12:49:36 MEMBER HAYES: So moved.

MR. ROATE: Motion made by Mr. Hayes, seconded by Dr. Burden.

Mr. Bradley.

MEMBER BRADLEY: Yes.

MR. ROATE: Dr. Burden.
MEMBER BURDEN: Yes.
MR. ROATE: Senator Demuzio.
MEMBER DEMUZIO: Yes.
12:49:50 MR. ROATE: Mr. Hayes.
MEMBER HAYES: Yes.
MR. ROATE: Chairwoman Olson.
CHAIRPERSON OLSON: Yes.
MR. ROATE: Five votes in the affirmative.
12:49:54 CHAIRPERSON OLSON: Motion passes and these documents are now part of the application.

Is there anything in these documents that would make the Board want to not review this project at this time?

12:50:11 (No response.)

CHAIRPERSON OLSON: All right. State Board staff report.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

12:50:18 The applicant is proposing to construct and establish a multispecialty ambulatory surgical treatment center. In addition, pharmacy equipment, cleaning and storage, and support space will also be constructed. As part of this construction, there will

be approximately 12,500 gross square feet of shell space. The total estimated cost of the project is approximately $16.3 million.

There was a public hearing on this project
12:50:49 and there was opposition. 21 criteria were addressed by the applicants, and the applicants failed to meet the size of the project, impact on other facilities, establishment of new facility, a reasonableness of project cost, new construction cost, A & E fees, and
12:51:12 moveable equipment standards.

Thank you, Madam Chairwoman.

CHAIRPERSON OLSON: Thank you, Mike.

Comments from the Board, please.

MR. MC KEVETT: Thank you. My name is
12:51:20 Tim McKevett. I'm president of Beloit Health System, and with me today is Ed Parkhurst from Prism Consulting; Dr. Pierre Charles, a general surgeon; Jason Dotson, vice president; Evie Rittenhouse, director of our surgical services; and Doug Wait, our construction
12:51:36 coordinator; and Mike Bua, who is a director of finance.

The project before you today is our request to develop a four-room ASTC, two multispecialty operating rooms, and two GI procedure rooms at our campus in Roscoe, Illinois. As part of that project,

it includes relocation of our current ambulatory procedural volume from Beloit Memorial Hospital, which in turn will allow us to modernize our existing operating rooms at our main campus and main hospital
12:52:08 facility.

We'd like to thank the Board for their consideration of this project and also for your original approval of our NorthPointe campus at your January 2006 meeting.

12:52:18 We believe that we have provided the information to support the project, which is based on, again, relocation of sufficient utilization attested to by our physicians in our application to support the four-room ASTC. We met 18 of the State Board's
12:52:38 criteria. We have six areas of noncompliance which we'll address, but they were also addressed in response to the SAR.

Before we elaborate and explain the issues on noncompliance, I would like to take a moment to provide
12:52:50 some brief comments on opposition points as well as global points.

First, Beloit is located directly on the state line. The state line is adjacent to us to our sister city; it cuts between us and South Beloit, which

is in Illinois. That the city is directly adjacent to Roscoe, which is where our NorthPointe campus is located.

We have strong local community support.

12:53:15 We're surprised by -- with the relocation of these cases to a new facility, we were surprised that it created so much opposition from providers that were 20 to 30 miles away. NorthPointe itself is only 9 miles away from our hospital facility in Beloit or 14 minutes.

12:53:31 There has been a question about licensing requirements, and we understand that we must meet all licensing requirements for both our physicians, as well as the facility, but to meet those standards we need to first have a facility to actually license for its

12:53:47 operation.

There was a comment about us moving into a better market. Our hospital was established in 1928, and we've been serving southern Wisconsin and the northern Illinois area since that time. Our market

12:54:00 characteristics and demographics are similar to those of other Illinois-based regional providers in opposition to the project. We've physically been in the Roscoe area since 1991 with a facility that provided physician offices and ancillary services. In

2007 after the Board's approval, we did relocate to our new campus on the NorthPointe facility in Roscoe. The point is, we are not moving into a new market; we've already been there.

12:54:30 In 2012 we saw 82,000 Medicaid patients. We provided $20.6 million in charity care, and the relocation of these cases will not change our payer mix. We're simply taking the buyer that we're seeing in our hospital now and moving it to the new facility.

12:54:48 We provide care to all those who seek our services both at our NorthPointe campus and at our hospital.

Secondly, I'd like to ask the Board to please consider the system characteristics. We're a not-for-profit integrated health care delivery system.

12:55:01 As a system, we coordinate continuum of care, including wellness prevention, physician offices, ambulatory and inpatient services, long-term care, and it's all tied together with an integrated medical record. This integration allows for the greatest degree of

12:55:18 effectiveness and efficiency, and to achieve that effectiveness and efficiency we need to utilize our own facilities to maximize the productivity and minimize the use of other providers outside of the system. We ask the Board to please consider these unique factors

in your deliberations.

Now I would like to briefly address the six areas of noncompliance, first being the size of the project.

12:55:41 We have a health system policy that when we can, we try and build to the same standards to provide more standardization. We think this is very critical in an operating room setting, so we designed our operating rooms and suites down at the NorthPointe 12:55:57 proposed facility to the same standards and square footage as the ORs in our hospital. This, again, will allow for standardization for our surgeons and our staff, promote safety, quality, and efficiency. We've also included additional space to ensure patient 12:56:12 privacy. We think this will enhance our patient satisfaction for both the patients and their families. We believe that this is a sound policy, and we hope that it justifies the increased space.

From a market capacity perspective, there's 12:56:28 an argument that we're out of compliance with an access capacity. What we would argue is that we're not increasing or adding capacity to the market; we're simply relocating cases from Beloit that we're currently seeing to the new facility. And, again, our

physicians have attested that they will move these cases. This will allow us to modernize our existing operating rooms as we add more surgical services in that area, including open-heart surgery. The permit
12:56:55 application, the SAR findings concur we have the required volume to support the ASTC.

The establishment or capacity at our existing hospital: Currently we have eight rooms (six ORs and two GI procedure rooms.) In our operating rooms, two
12:57:12 of the rooms are dedicated to specialty use, one of them being urology and the other one being our open-heart or cardiac surgery suite. This brings our operating rooms down to four, and as a hospital with an emergency room, we're required to keep one of those
12:57:31 four open for emergency C-sections or trauma cases that would come in. So we're really down to three functional ORs. By adding the additional two ORs and two procedure rooms at our NorthPointe proposed facility, this would bring us to a total of 9 to 10 ORs
12:57:46 which, again, is within the State standard.

As far as improved access criteria, we believe we're giving greater access to the patients we're currently seeing at our NorthPointe campus, and it's also important that we increase access for our

Beloit patients utilizing the facility. It's not uncommon, especially in a hospital setting, for our patients to come in for an elective outpatient surgery case because of the emergency nature of cases that we
12:58:10 do see to get bumped and spend the whole day at our facility, and this will improve their access to care where they can come in and be done in one location.

The construction costs of 6 percent higher than the State standard, when we engaged in an
12:58:26 independent construction consultant, we were advised that it's primarily due to the location factor of the Rockford market where the costs are higher.

Our architectural and engineering fees are based on the total cost of the project. They fall
12:58:43 within the 8 percent range. If we focus just on the clinical end of the project, we wouldn't be out of compliance, but we're applying the architectural fees to the total project, which brings us to 8 percent, which is in between the 7 and 10 percent that's
12:58:58 required by the State.

From an equipment cost perspective, again, we included the equipment for the entire project, and the scope of the services that we'll be providing in the proposed ambulatory surgery center are similar to what

we will in the hospital, thus requiring us to have increased equipment for the breadth and scope of services that we'll be providing.

Thank you once again for this opportunity to present our permit application. I would like to ask for just a couple of comments from the team to elaborate further on some of the issues in the opposition and from a compliance perspective.

With that, first I'd like to ask Dr. Charles to comment.

DR. CHARLES: Thank you, Jim.

I'm Dr. Pierre Charles, general surgeon. I've been in Beloit for 17 years, and I've practice at NorthPointe in northern Illinois for the last six years along with my practice in Beloit. Obviously, I'm licensed in both states, Illinois and Wisconsin.

I perform about 400 surgical cases per year, 60 percent of which are considered outpatient cases. In our situation at this time, I practice with 23 other surgical or procedural specialists, 20 surgeons, and three industrialists. We have six operating rooms, as Tim has alluded to, which puts a crunch on the availability of OR time and space.

Being able to shift these outpatients --

these outpatient surgeries to an outpatient center will allow flexibility in the operating schedule at the hospital. Also, it would improve or allow us to improve our current facility.

13:01:03 More importantly, the outpatient situation, outpatient setting, otherwise known as the ambulatory surgery center, provides patients with a comfort zone that if you look statistically, patients around the country have reported that they typically feel better

13:01:22 served at outpatient surgery centers for outpatient procedures.

Keeping patient safety in mind, patient comfort in the mind, the ease of scheduling, the ease of flow, these are all things that we are proposing,

13:01:37 and we respectfully ask that you consider our proposal.

MR. MC KEVETT: The next individual I'd like to ask to make some comments is Jason Dotson, our vice president over the clinical area in the NorthPointe campus.

13:01:54 Jason.

MR. DOTSON: Good afternoon. I'm the vice president of Beloit Health System, as Tim mentioned. I'm here today to ask for your support of this project and address our outdated facilities and

the alternatives we considered.

The existing surgery and GI facilities are located on the second floor of Beloit Memorial Hospital and date to the hospital's planning and development in
13:02:14 the 1960s. Hence, their general design is based on guidelines established approximately 50 years ago. The surgical suite was developed when the original hospital was constructed in 1967. The gastrointestinal procedural suite is, in fact, a converted patient care
13:02:34 unit contiguous to the circle suite. Neither area meets contemporary design and design standards, and space is at a premium as currently our operating rooms are 200 square feet smaller than contemporary facility guidelines.

13:02:54 The current design is based on a patient delivery model, and the facilities have been adapted to shift from an inpatient to primarily outpatient ambulatory care delivery model. Outpatient cases and GI cases are compromised given the fact that the
13:03:11 existing facilities were designed around an inpatient care delivery model which did not contemplate, by way of example, adequate pre- and postsurgery recovery space, private and conveniently located restrooms, family waiting areas and patient support areas.

As you know, we explored five conceptual alternatives to provide this new outpatient care delivery model. Some have stated that we did not explore development of an ambulatory surgery center on
13:03:46 our hospital campus. That is simply not true, as this was stated in our application and considered in two of our alternatives. We did not choose the other two alternatives as they are more expensive and do not achieve the highest levels of efficiencies, privacy,
13:04:04 and comfort for our patients that we desire. Instead, we chose the alternative that provides a convenient and efficient and private way of providing care to our patients at the least cost.

As we are an integrated delivery health care
13:04:26 system, we are approaching to do what is best for our patients that we currently serve by relocating resources to an outpatient facility within our system in Illinois. Sending patients to another existing facility in Rockford or Belvidere would not benefit our
13:04:42 patients as it would increase the amount of travel time of up to 50 minutes round-trip, thus wasting time which is our most precious commodity.

Further, using services would not benefit the system due to fragmented care, reduced physician

productivity, as well as defeating the purpose of developing a comprehensive integrated delivery model, especially in light of the Affordable Care Act provision to decrease health care costs and improve access.

13:05:14 Two points I would like to clarify. The in-market capacity is less than our opposition has stated, and we don't know if it would become available to our physicians. As a side note, State Board might wish to compare certain opposition testimony regarding

13:05:31 case times in contrast to the reported data. There seems to be several discrepancies in both case hours and whether or not they are single- or multispecialty.

Further point of clarification, the majority of our physicians have an Illinois license, and those

13:05:49 that have attested have an Illinois license with the exception of five physicians in which we have no reason to believe they will not be able to obtain their Illinois license.

I thank you for your time today and ask for

13:06:04 your support of our project by providing a vote of yes for the CON. By doing so, you will allow us to relocate outpatient cases performed at Beloit Memorial Hospital to our outpatient campus in Roscoe and, most importantly, add efficiency, privacy, and reduced cost

in our integrated system, allowing us to add value by providing our patients what they deserve, access to the highest quality of care in the most appropriate local setting.

13:06:37 Thank you.

MR. MC KEVETT: Thank you. At this time we would entertain any questions that the Board might have.

CHAIRPERSON OLSON: Questions from

13:06:49 the Board?

Dr. Burden.

MEMBER BURDEN: Thank you, Madam Chair.

This is to me a unique type of application in that several things occur to me I don't normally

13:07:03 encounter, and perhaps I could be swayed from that opinion by these questions.

MR. CONSTANTINO: Dr. Burden, could you speak into the microphone?

MEMBER BURDEN: I'll talk louder.

13:07:30 I have some questions that I thought would help me come to a reasonable conclusion.

It appears to me from what I hear that we're talking about a facility that needs to be updated, needs certainly today's modern trend towards outpatient

facilities as the doctor has mentioned regarding his surgical practice which is not unique, it's true all over the country, and my experience traveling around -- I'm a little bit older than everybody here, so I've
13:08:01 been through a lot of cases in different surgical arenas.

I get a sense that this is sort of a town-versus-gown kind of issue because the community of Rockford and the other ambulatory treatment centers
13:08:22 seem somewhat challenged by the scope and influence of your group.

Beloit Memorial Hospital's physician staff, are they all salaried? Is this vertical integration handled economically, as well? Is it a model based on
13:08:40 what you might see at Cleveland or Rochester or whatever?

MR. MC KEVETT: There's different models that we use. A new doctor coming in will be given a guarantee. When those doctors come off of that
13:08:55 guarantee, it's based on production but also some salaried positions with incentives.

MEMBER BURDEN: It's not a major thing, but it helps me explain since 5 percent of doctors were salaried when I left 15 years ago, now it's 39, and

there will be a lot more shortly because the younger generations that I encounter are all oriented toward security as opposed to hanging up a shingle.

I admit that was the first question, and the 13:09:25 other one I don't think is a big one, but does Wisconsin have a CON system?

MR. MC KEVETT: They do not.

MEMBER BURDEN: Monroe and LaCrosse have huge clients, and they seem to do what they care to do 13:09:40 with impunity. Am I right off on that?

MR. MC KEVETT: They had a CON version of it, but it sunsetted in the early '90s.

MEMBER BURDEN: Would the application endorse what I think I heard, that there's a real need 13:09:57 to revamp and redo your institution and that the idea of having an ambulatory surgical treatment center within 15 minutes of your location allow surgical procedure essentially to go forward without, shall we say a slowdown in what's occurring at the current 13:10:17 facility? Is that underlying here? Is it overt? Is it implied?

MR. MC KEVETT: That is correct. It will allow us to, one, serve the outpatient ambulatory surgery patients in a more appropriate setting, and

two, allow us to go back and modernize our existing ORs at our main facility.

MEMBER BURDEN: Now, my last question is really directed towards Mr. Constantino, who is
13:10:44 accustomed to having me work him over.

We didn't acquire a Beloit Memorial Hospital profile in 2012, and that's because the hospital, per se, is not making the application. The application is for the ambulatory surgical treatment center, but I
13:10:56 read that this application implies as much what's going on at the hospital as what they hope to do in the ambulatory surgical treatment center, which is why I asked that question.

It would help me if I could see med/surg
13:11:11 occupancy, utilization of the ORs they already have. I've been told that they need to be revamped. Fine but I'd like to know utilization which I don't have access to. Is that inappropriate of me to ask that question of you, Mr. Constantino?

13:11:24 MR. CONSTANTINO: Well, they're a Wisconsin facility. We have no jurisdiction over that facility. We don't collect that data. I can make that request for you, though, to the applicants.

MEMBER BURDEN: I bring it up because as

a physician, in looking at this application I want to see some documentation of what I hear. I can assume that everything here is being presented in a forthright manner, and I certainly think I understand the needs of
13:11:51 surgeons on the staff being a surgeon myself, and also for utilization and squeeze emergencies coming in, blah, blah, blah, but I'd like to see the data that would help me lean very favorably maybe to what you want to have accomplished at your knew outpatient
13:12:08 facility.

MR. PARKHURST: Dr. Burden and Mr. Constantino, the application does include the surgery utilization by specialty for the last three years in the same format as the AHQ and the
13:12:28 published information. So the surgery utilization is included in the application, and I think Mr. Constantino used that information to average utilization and to look at the hours, and he will have to comment on that.

13:12:42 What is not in the application is what you just suggested, emergency room utilization and so forth. But the surgery utilization is in the application, and give me a moment and I can reference the page for you if you'd like.

MEMBER BURDEN: I've seen that. That doesn't answer my question. My question is pretty basic.

MR. PARKHURST: And the bed utilization 13:13:07 is in here, also.

MEMBER BURDEN: The hospital profile is something that I regularly peer at. I like to evaluate exactly how much Medicaid is being done, how much charity care is coming out of the institution. I'm 13:13:20 influenced by those things in terms of the community. I'm well aware of Rockford's situation where you've got upwards of 13 percent unemployed and problems in that community are substantial. All of this independent of being a surgeon, I'm also focusing on the needs of the 13:13:36 community, the problems of the community, and how effectively you as an institution are handling them. Utilization of the OR, that can be -- I've been on many a committee. That data can be manipulated however you want to sell it, but I want to see a hospital profile 13:13:56 which I don't think is as easy to convince someone we have a problem here, we've got to move or at least we need another --

MR. PARKHURST: Maybe two things. One is the information that is in the application, that

does fit the profile at least for surgery, as you said.

The second is in the 11/22 information, the charity care, amount of patients, and so forth has been reported, and that information is, as far as I know, 13:14:24 consistent with how it would be reported with respect to the age given the information on the annual surveys.

MEMBER BURDEN: You're probably right. I plead old age habit. I look at something I see, I recognize what I see here. That's all I'm asking.

13:14:42 And I've taken up more time than probably necessary, but I do think it's important to know if this to me resembles what I hear the community that is opposed to you. There is active opposition to what you want to do, and I find it very difficult to come to 13:15:01 conclusions without evaluating all the matter for me as a retired physician that I like looking at. Maybe I'm the only one on the Board that feels that way but that's it. If you get more, it would help me but we'll go forward.

13:15:16 Thank you very much for your time.

CHAIRPERSON OLSON: Other questions for the Board?

MR. CARVALHO: Thank you, Madam Chair. When a court hears a case, one of the things a Judge

wants to know is, if we decide this way, what's the impact going to be on other cases.

So there is something that you said regarding justification for the Board approving the application notwithstanding some of the conclusions of the staff that the application isn't in accordance with the rules. And in particular it's the observation about the Affordable Care Act integrated care and integrated organizations, and I want to make sure I understood what you said so I don't mischaracterize it. And if I am characterizing it correctly, I want to make sure that the Board understands the implications of that and give you an opportunity to say, no, this is why it won't have this implication.

13:15:50 13:16:09 13:16:24 13:16:46

You're right that the Affordable Care Act certainly encourages integrated delivery of care. Where I have trouble is the notion that the only way to get there is through a common umbrella of ownership. Because if the only way to get integrated care delivery is through common ownership as opposed to contractual relationships, then I worry what you're basically saying to the Board is everybody gets to have one of everything, and so the whole premise of the CON process that we only see how many does the system need -- I

don't mean your system, I mean the health care system -- gets blown out of the water if everybody gets to say, "Well, I know there's enough of this or enough of that, but since I don't own one, you should make an exception 13:17:19 and let me have one, too." That will -- I mean, that basically cuts the CON process from the inside out.

So have I misunderstood your argument that because you want to be an integrated delivery system you think the only pathway there is to own something as 13:17:39 opposed to a contractual requirement, and if that is your argument, why doesn't that blow the whole CON program out of the water?

MR. MC KEVETT: You did misunderstand. Our reference to the Affordable Care Act was about the 13:17:50 necessity to be more efficient, and our model to do that was through an integrated delivery system. There are other models out there. For us the need --

MR. CARVALHO: You're misunderstanding me. An integrated care delivery system just means that 13:18:05 there's a coordination of everything from cradle to grave. It doesn't mean that somebody owns -- one entity owns all of it. You can develop -- there are in this state models of integrated care delivery systems that are not premised on owning everything.

So why -- in your argument you said, "Well, to be an integrated care delivery system we need one of these." Why can't you do it contractually and still have an integrated care delivery system?

13:18:35 MR. MC KEVETT: Well, in effect we do contract, and we have relationships with the University of Wisconsin Hospital in Madison, we have an affiliation and relationships with other hospitals. Some of them are in the Rockford market.

13:18:50 Our system and in this case we are integrated -- we have our employee physicians; we have a unified medical records for our surgical cases and things that we do here. So for us being very efficient, not duplicating tests, we might have to send

13:19:08 someone else out to another provider, if they go through another institution we don't want to replicate some of those testings for the patients and including our doctors.

MR. CARVALHO: We are talking past each

13:19:20 other. Let's just hypothesize so it's not exactly your proposal but a hypothetical I'm talking about.

If there is some component in the integrated health care model that you don't own and you don't run but you enter into a contract with somebody -- let's

say, for example, you don't do end-stage renal dialysis, but you know you're going to be an accountable care entity or some of your patients are going to need that, and you want it all kind of within
13:19:51 the family. You enter into a contractual relationship with an ESRD, and in that contractual relationship you agree to share all your data, and they get access to your data, and you get access to their data so everyone knows what care has been delivered. There's no
13:20:08 duplication of care; there's no duplication of testing; it's all handled through, if you will, an integrated health care information exchange between you and all your components of your system.

That gets you to the lack of duplication.
13:20:23 It's just that you don't happen to own it; you get that piece of your integrated care delivery model through contract rather than ownership. You can have an efficient integrated care delivery system without ownership of each of the pieces.

13:20:37 MR. MC KEVETT: I would agree with you. In point of fact, we do.

CHAIRPERSON OLSON: Other questions?

(No response.)

CHAIRPERSON OLSON: I actually have a

couple questions, if I may.

I wanted to go back to the alternatives that you considered.

On page 10 of the State staff Board report, 13:20:58 No. 3, am I correct that what you're talking about in this particular option is a six-room ambulatory surgery center, and what you're actually proposing here is a four-room ambulatory surgery center. So, in effect, wouldn't that make the cost of putting an ambulatory 13:21:19 surgery center on your campus cheaper than it is putting it in at NorthPointe?

And, also, I'm trying to figure out -- there's two separate pieces to that, 3A and 3B. And 3B is actually cheaper to build it on your existing 13:21:34 campus rather than in Illinois. I'm trying to understand why you wouldn't use that option.

MR. PARKHURST: So maybe I can respond to that.

In working with the hospital and putting the 13:21:43 alternatives together, the six-room alternative on the campus assumes that the existing surgery suite in the hospital would only be an inpatient suite, and all of the outpatient cases would move into the six-room suite.

The model that is being proposed as the least cost alternative would still retain some ambulatory surgery in the hospital environment because of the acuity of the patient and sensitivity and so forth, and
13:22:13 the cases that have been attested to that support the four-room suite are only those -- it's a portion, I should say, of patient cases that would be moved into the ambulatory environment that is at the NorthPointe campus.
13:22:27 So it's looking at the actual definition of what might be done between the six-room and the four-room suite if that helps.

CHAIRPERSON OLSON: I didn't follow that. I'm not following that at all.

13:22:42 MR. PARKHURST: Essentially, not all of the outpatient cases currently occurring are proposed to be moved to NorthPointe.

CHAIRPERSON OLSON: But you could build a four-OR ASTC on the campus of your current hospital
13:23:01 cheaper than you can build it in Illinois. I understand what you're saying, utilization would be different, but it would be cheaper.

MR. PARKHURST: I don't believe that to be true. I think we may have to come back to the Board

and clarify those questions for you.

CHAIRPERSON OLSON: I actually have another question. Based on the comments that were made, can I make the assumption based on your comments 13:23:25 that you would be seeing Medicaid patients at this ASTC?

MR. MC KEVETT: We would.

CHAIRPERSON OLSON: Any Medicaid patients presenting at your ASTC would be seen?

13:23:40 MR. MC KEVETT: That's correct.

CHAIRPERSON OLSON: You have a couple doctors licensed in Illinois, I understand that, but how would you get around the fact that these doctors have to be active staff in an Illinois hospital in 13:23:50 order to practice at an Illinois ASTC? I know you addressed that but I don't see the plan.

MR. MC KEVETT: We have relationships with several Rockford hospitals. We have relationships with other hospitals in the region that we know we 13:24:04 would need to meet that requirement, and we would have those physicians licensed at those facilities.

CHAIRPERSON OLSON: Thank you. Any other questions for the Board?

(No response.)

MR. MC KEVETT: Madam Chairman, at this time I would like to request a deferral so we can get back to some of the questions that the Board has raised today and also have the opportunity to present the full
13:24:28 project to the entire Board. We respectfully ask for that deferral.

CHAIRPERSON OLSON: That doesn't require a vote. So if you choose to do that, we can do that.

And in the meantime, if Board members have
13:24:52 other questions, could you get those to Mike or to Courtney so that the applicant can address those?

MR. MC KEVETT: Thank you very much.

CHAIRPERSON OLSON: Thank you.

Next, we have Adventist LaGrange Memorial
13:25:36 Hospital. Actually, if we could have Adventist Hinsdale Hospital come up, as well. Are they the same representatives.

MR. DAVIS: Yes.

(Five witnesses duly sworn.)

13:26:09 CHAIRPERSON OLSON: Mike, State Board staff report.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The applicants are proposing to establish a

16-bed comprehensive physical rehab category of service. The cost of the project is approximately $2.3 million. State Board staff notes the applicant viewed this project as a relocation of comprehensive
13:26:35 rehab services from one facility, Hinsdale Hospital, to another, LaGrange Memorial Hospital. These facilities are approximately seven minutes apart and are located in the same rehab planning area.

Under current State Board rules, the projects
13:26:54 are viewed as an establishment of a 16-bed rehab service at LaGrange Memorial Hospital and a discontinuation of a 15-bed rehab service at Hinsdale Hospital.

If the State Board should approve this
13:27:12 project to establish a 16-bed physical rehab category of service, the applicants are proposing to discontinue the 15-bed physical rehab category of service at Hinsdale Hospital. If both projects are approved by the State Board, the result will be an increase of one
13:27:32 bed in the comprehensive physical rehab planning area.

There was no public hearing and no opposition letters received by the State Board staff. The applicants failed to meet two criteria. One was the size of the project and, two, the planning area need.

The February 2014 Inventory of Health Care Facilities indicated a calculated excess of 68 physical rehab beds by calendar year 2015.

Thank you, Madam Chairwoman.

13:28:07 CHAIRPERSON OLSON: Thank you, Mike.

Comments for the Board?

MR. DAVIS: Good afternoon, Madam Chair, members of the review board, and the review board staff. My name is Larry Davis. I'm the chief

13:28:22 executive officer of Adventist LaGrange Memorial Hospital. I want to thank you and you staff for the opportunity to present our permit request for the establishment of comprehensive physical rehabilitation services.

13:28:35 Sitting at the table with me today are Mr. Mike Goebel, who is the CEO of Adventist Hinsdale Hospital; Ms. Jane Mitchell, director of rehabilitation services for Adventist Hinsdale Hospital and Adventist LaGrange Memorial Hospital; and Dr. Megan Parkes, the

13:28:50 medical director for rehabilitation services at Adventist Hinsdale Hospital. We are also pleased to have here Cristina Moyer, who is the regional director of planning for Adventist Midwest Health, who is sitting behind us at this point in time. She's also

available to answer questions if need be.

Adventist LaGrange Memorial Hospital and Adventist Hinsdale Hospitals are part of Adventist Health System, a not-for-profit health system with
13:29:29 44 hospital campuses nationwide. Here in the Chicago area Adventist Midwest Health operates four hospitals, including the only disproportionate share hospital in DuPage County, which is Adventist Glen Oaks Hospital. Adventist Bolingbrook Hospital in Will County also
13:29:49 treats a high volume of Medicaid patients and recently opened a Federally qualified health center at their campus in conjunction with the Visiting Nursing Association.

While the project -- proposed project is for
13:30:01 the establishment of a new category of service, it's actually a relocation of the existing unit at Adventist Hinsdale Hospital. Adventist Hinsdale Hospital's rehabilitation program has a long-standing history of excellence and offers exceptional inpatient care. It's
13:30:18 accredited by the Commission of Accreditation of Rehabilitation Facilities and has maintained this accreditation since 1987. In addition, it was granted stroke specialty certification during its most recent survey. And to further ensure the commitment to

excellent rehabilitation services, Adventist Hinsdale Hospital has partnered with Marianjoy Rehabilitation Hospital for administrative and clinical oversight and support. All of this clinical and operational
13:30:51 expertise will be seamlessly transferred to Adventist LaGrange Memorial Hospital pending your approval today.

The State Agency report shows that there's an excess of beds in the planning area. However, there continues to be a demand for rehabilitation services
13:31:08 due to the needs of the ageing population in our market area. Although historical utilization has demonstrated the need for the service with an occupancy of 83.1 percent, we have also projected that inpatient rehabilitation services will grow by 2.5 percent
13:31:26 annually, achieving the targeted occupancy of 85 percent by 2016. The new location will allow for the necessary space and resources needed to serve this growing patient population well into the future.

The patient care center at Adventist LaGrange
13:31:42 Memorial Hospital was completed was 2006 and has provided the hospital with state-of-the-art patient rooms. While the rooms are slightly larger than the State standard, they were designed to accommodate family members, as well as caregivers, facilitating

communication which is the critical element to rehabilitation patients as they make the transition to their home environment.

Finally, I'm very pleased to note that there
13:32:07 is no opposition to this project and believe this speaks to our long history of providing quality rehabilitation here to the community we serve.

Thank you for your consideration of this project, and we are happy to entertain any questions
13:32:20 you may have at this time.

CHAIRPERSON OLSON: Thank you.

Questions for the applicant anyone?

Dr. Burden.

MEMBER BURDEN: Thank you, Madam Chair.

13:32:29 I'm just curious. It doesn't appear to me that this application is doing anything to the planning area need, just shifting from one institution to another without addressing beds. Correct?

MR. DAVIS: We're adding one
13:32:41 additional bed.

MEMBER BURDEN: Well, according to the State Board standard there are 68 comprehensive physical -- calculated in excess of 68 beds. That's what I'm looking at, not necessarily -- your

application does not address that issue. That's how I read it. Is that correct?

MR. DAVIS: What we're doing.

MEMBER BURDEN: Adding one bed is not really an issue of my --

13:33:06

MR. DAVIS: What we're doing is transferring the service from one hospital to another.

MEMBER BURDEN: I understand that part but I'm asking a question. This doesn't address the planning area need just independent of the fact that there's 68 excess beds.

13:33:17

CHAIRPERSON OLSON: I think even if they were adding -- at this point, in the day-to-day, even if they were not even having one net gain bed, it would still not meet that criteria because we haven't discontinued these beds. I understand what you're saying, and I think you're absolutely right.

13:33:31

MEMBER BURDEN: I didn't get an answer to that. My math isn't great but I see no -- and that's independent of your application. That's what I'm saying. You're moving beds from one institution to another, same number, maybe one is increased, but our State Board has already said to us that we've got 68 too many. There's no effort to reduce the number of

13:33:47

beds in this application?

MR. DAVIS: That's correct. We're just trying to continue to serve the patients that are currently --

13:34:12 MEMBER BURDEN: That's fine, although our State Board thinks there are 68 more than we need. That's what I'm saying. I don't have any problem with what you're trying. I'm trying to make clear what I understand the State Board has told me to look at.

13:34:27 MR. DAVIS: That's correct.

CHAIRPERSON OLSON: Other questions or comments?

MEMBER HAYES: Madam Chair.

You basically have -- you were thinking of

13:34:41 rehabilitating or modernizing this floor and this program in 2013, and then through your corporate -- or through Adventist you've basically decided to go another route, to basically move these beds over into LaGrange; is that correct?

13:35:06 MR. DAVIS: Since we're part of the same corporation, we looked at a lot of different alternatives as to where we could locate this particular unit. And what we ended up finding was that it was cheaper for us to be able to build the beds over

on the LaGrange campus versus having the beds rebuilt at the Hinsdale site.

MEMBER HAYES: Why was that the case? You've talked to -- you've had the Attorney General and
13:35:36 this was -- basically, the Attorney General was concerned about the -- this program at Adventist Hinsdale; is that correct?

MR. DAVIS: The concern of the Attorney General was regarding the ADA access, and we made an
13:35:53 agreement that we would resolve that particular concern.

At the point then we looked at various options as to where this facility or this service should be located, we identified that, again, it was
13:36:05 cheaper for us to be able to construct this at the LaGrange campus.

MEMBER HAYES: Now, at the LaGrange campus, are you doing any -- where are these beds going? I mean, do you already have space at LaGrange
13:36:21 to be able to do this?

MR. DAVIS: That's correct. We have some unused medical/surgical beds that will be converted to acute rehab service beds.

MEMBER HAYES: So this is helping with

these unused beds at LaGrange Hospital?

MR. DAVIS: That's correct.

MEMBER HAYES: Now, the occupancy at Hinsdale has traditionally been higher than at

13:36:54 LaGrange; is that correct?

MR. GOEBEL: Inpatient occupancy.

MEMBER HAYES: Inpatient occupancy has been higher than LaGrange.

MR. GOEBEL: Yes. We run between

13:37:06 140 and probably 190 patients total, all inpatients every day.

MEMBER HAYES: At Hinsdale?

MR. GOEBEL: Yes.

MEMBER HAYES: What about LaGrange?

13:37:17 MR. DAVIS: We're running about 100 patients, inpatients.

MEMBER HAYES: Okay. Thank you very much.

CHAIRPERSON OLSON: Other questions?

(No response.)

13:37:32 CHAIRPERSON OLSON: There being none, I'll entertain a motion to approve Project 13-073 Adventist LaGrange Hospital to establish a 16-bed comprehensive physical rehabilitation unit at LaGrange Hospital.

Now, do we have to take this in two separate motions, or can we make this motion contingent on --

MR. URSO: We could.

CHAIRPERSON OLSON: Would that make the
13:37:58 Board more comfortable to make one motion, or do you want it in two motions?

(No response.)

CHAIRPERSON OLSON: Then in order to approve the establishment of the 16-bed facility, they
13:38:07 have to agree to discontinue the other facility.

MEMBER BURDEN: Personally, it's a little cleaner to do it in two motions.

CHAIRPERSON OLSON: That's fine. May I have a motion then?

13:38:17 MEMBER BRADLEY: So moved.

MEMBER BURDEN: Second.

CHAIRPERSON OLSON: Roll call.

MR. ROATE: Motion made by Mr. Bradley, seconded by Dr. Burden.

13:38:28 Mr. Bradley.

MEMBER BRADLEY: Yes.

MR. ROATE: Dr. Burden.

MEMBER BURDEN: Yes.

MR. ROATE: Mr. Hayes?

MEMBER HAYES: I'm going to vote yes because I think basically the project itself can trump any of the State Board findings here on the size of the project and the planning area need.

13:38:54 MR. ROATE: Thank you.

Senator Demuzio.

MEMBER DEMUZIO: Yes.

MR. ROATE: Chairwoman Olson.

CHAIRPERSON OLSON: I vote yes for the

13:39:04 reasons stated.

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

CHAIRPERSON OLSON: The motion passes.

Do you have another presentation on this next

13:39:11 application?

MR. DAVIS: The same presentation.

Questions from the Board?

(No response.)

CHAIRPERSON OLSON: Seeing none, I would

13:39:23 like a motion to approve Adventist Hinsdale Hospital to discontinue a 15-bed comprehensive rehabilitation unit at its hospital in Hinsdale.

MEMBER BURDEN: So moved.

MEMBER HAYES: Second.

MR. ROATE: Motion made by Dr. Burden, seconded by Mr. Hayes.

Mr. Bradley.

MEMBER BRADLEY: Yes.

13:39:45 MR. ROATE: Dr. Burden.

MEMBER BURDEN: Yes. Because of the prior discussion regarding planning need.

MR. ROATE: Thank you.

Senator Demuzio.

13:39:53 MEMBER DEMUZIO: Yes.

MR. ROATE: Mr. Hayes?

MEMBER HAYES: Yes. Because of the discussion concerning Adventist and their corporate need and the transfer of these beds to LaGrange

13:40:12 Hospital. So I'm going to vote yes.

MR. ROATE: Thank you, sir.

Madam Chair Olson.

CHAIRPERSON OLSON: I vote yes based on the beds being transferred to LaGrange.

13:40:23 MR. ROATE: That's five votes in the affirmative.

CHAIRPERSON OLSON: Motion passes. Thank you very much.

Next we have Jersey Community Hospital in

Jerseyville.

(Three witnesses duly sworn.)

CHAIRPERSON OLSON: Mike, State Board staff report.

13:41:18 MR. CONSTANTINO: The applicant is requesting to discontinue its 6-bed OB category of service. There is no cost to this project. There was one opposition letter, no findings, and no public hearing requested.

13:41:32 Thank you, Madam Chairwoman.

CHAIRPERSON OLSON: Comments for the Board?

MR. MOON: Members of the Board, thank you for the opportunity to present this project to you

13:41:42 today. My name is Shawn Moon. With me today is Jon Wade, CEO, and Julie Smith, director of nursing at the hospital.

We are before the Board seeking the discontinuation of the obstetrics unit at the hospital.

13:41:56 We know that the State Agency report was generally positive with respect to this project. As such, Mr. Wade will provide a short presentation, following which we'll answer any questions.

MR. WADE: Thank you for the opportunity

discuss this project with you today.

Jersey Community Hospital is a 65-bed rural Illinois hospital district serving Jersey, Greene, and Calhoun Counties. The hospital currently provides 13:42:23 medical/surgical, pediatric, and obstetric care to the residents of these counties. We're proposing distinction of the obstetrics unit primarily for three factors: Lack of demand, high cost, and the lack of staff.

13:42:35 With regard to the demand, over the past three years we've had an occupied bed census of less than one. Coupled with the decreasing trends in deliveries in our counties, we don't see that getting any better.

13:42:57 The decrease in volume makes it really difficult to float the cost of such a department, and we saw significant loss last year, and we're not able to sustain that going forward and really don't expect, like I said, more volume from that.

13:43:20 We have worked to continue to provide the services that we can in the area. We've worked with other regional providers. Our hope is that we can continue to provide services with the exception of the delivery beds at our hospital, and we're working on a

program now that would allow for an outreach clinic from Alton to come up and provide a five-day-a-week clinic on our campus that would continue to provide those services, just the delivery would not happen at
13:43:55 our hospital.

It's a difficult decision for our local hospital board to come to. They've invested a lot in the facility and recruiting over the last several years but just feel like there's really limited options
13:44:10 available to us and felt like it was the more responsible thing to do to proceed with a partner that would help us provide these services than to do it ourselves.

So as such, we ask for the Board's approval
13:44:25 of this project and are happy to answer any questions.

CHAIRPERSON OLSON: Thank you.

Questions or comments from the Board?

Dr. Burden.

MEMBER BURDEN: Thank you very much,
13:44:41 Madam Chair.

It seems unfortunate but it looks like, based on what we see in numerous applications from the southern part of the state, going forward for an institution such as yours, even as a critical access

institution might be very challenging. The census running in the institution, I've got in front of me peak census 21 beds -- is that about right? -- and less than that often. Correct?

13:45:21 MR. WADE: Right.

MEMBER BURDEN: I appreciate what you said and am sympathetic.

MR. WADE: Thank you.

MEMBER DEMUZIO: You have -- did have

13:45:34 and probably always did have a great facility there when it came to OB. When was -- how long has that been? Did you say seven years?

MR. WADE: How long have we had --

MEMBER DEMUZIO: Because I've been

13:45:49 there. I know you've had huge population -- was it seven?

MS. SMITH: It's been eight.

MEMBER DEMUZIO: Eight years. And I know you had a huge population of OB cases going

13:46:02 through there and you rehabbed the facility. What are your plans now for that space?

MR. WADE: That's a difficult question for us because it's about 10 percent of our footprint. It's a significant amount of space. It's a beautiful

space like you mentioned, and we looked back at the last community needs assessment that was done with the county health department, and their top three items on there relate to heart services, cancer, or behavioral
13:46:38 health, none of which we offer to any significant degree.

So we don't have a plan right now. We hate to really tear up that nice space, so it's unknown at this time.

13:46:52 MEMBER DEMUZIO: What was the square footage? I know it was a large facility and it was beautifully done, and that's why I was wondering because I know that that was a big population for the hospital at one point.

13:47:07 MR. WADE: I don't remember the square footage offhand.

MEMBER DEMUZIO: Well, you're going to have a tough decision because I know that was a big population.

13:47:16 CHAIRPERSON OLSON: Other questions?

(No response.)

CHAIRPERSON OLSON: Seeing none, I would entertain a motion to approve Project 13-077, Jersey Community Hospital to discontinue the 6-bed obstetrics

unit at Jersey Hospital.

MEMBER DEMUZIO: I'll motion.

MEMBER BURDEN: Second.

MR. ROATE: Motion made by Senator
13:47:35 Demuzio, seconded by Dr. Burden.

Mr. Bradley.

MEMBER BRADLEY: Yes.

MR. ROATE: Dr. Burden.

MEMBER BURDEN: Yes.

13:47:44 MR. ROATE: Senator Demuzio.

MEMBER DEMUZIO: Yes.

MR. ROATE: Mr. Hayes?

MEMBER HAYES: Yes, based on that the applicants have met the requirements of the
13:47:53 discontinuation in the State Agency report.

MR. ROATE: Thank you, sir.

Chairwoman Olson.

CHAIRPERSON OLSON: Yes, based on the positives in the State Agency report.

13:48:09 MR. ROATE: Five votes in the affirmative.

CHAIRPERSON OLSON: Motion passes.

Next, United Urology Center LaGrange.

(Three witnesses duly sworn.)

CHAIRPERSON OLSON: State Board staff

report.

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The applicants are proposing a change of ownership of a single-specialty ASTC in LaGrange, Illinois. The estimated cost of the project is $728,000. There were no findings, no public hearing, and no opposition.

Thank you, Madam Chairwoman.

13:48:56

13:49:12

CHAIRPERSON OLSON: Thank you, Mike.

Seeing that there's no opposition and no findings, do you have a presentation, or would you like to open it to the Board for questions?

MR. COHEN: We will open it up to the Board for questions.

13:49:24

CHAIRPERSON OLSON: Questions or comments from the Board?

MEMBER HAYES: I'm -- I did receive and review the evaluation report that basically came up with a value for this facility of $750,000.

13:49:38

You know, in this report I notice they do have -- they talk about -- they talk about historical findings in the statement, but they never really used them.

I also notice that this note that is going to be given for the purchase price here has accepted a five-year free cash flow promissory note in the amount of $725,000 at 5 percent interest from United Shockwave
13:50:24 Services, Limited, and it talks about what free cash flow is.

What is the -- so in this note here actually for $728,000 they were -- how do you expect to be able to pay this note when this valuation performed
13:50:48 basically says that they were unable to come up with by using historical information free cash flow? I was kind of -- I was just wondering how that will work.

MR. COHEN: Well, with the transfer of the license from United Urologist Centers to United
13:51:09 Shockwave Services there will be cash flow in United Shockwave Services, so it's anticipated that that would be used to pay the note over time. And to the extent that it isn't, that's why I think the stipulation is that it's from free cash flow above and beyond what's
13:51:24 available to operate the ASC.

MEMBER HAYES: But United Urology Services, they basically have not been profitable or have essentially distributed all their profits, and so there hasn't been any free cash flow.

MR. COHEN: Correct. In the past that is correct.

MEMBER HAYES: But now you expect there to be free cash flow to pay off this note?

13:51:49 DR. COHEN: We do. And remember, too, in some respects they're all related entities, but this was done really to necessitate -- really to allow the two founders of the company to retire. So we're transferring the license from one entity to the next to

13:52:14 facilitate that. We've already handled the rest of those transactions, and that's the last step in this.

MEMBER HAYES: In this valuation report -- this was done by a firm of Frost, Ruttenberg & Rothblatt?

13:52:32 DR. COHEN: Correct.

MEMBER HAYES: Now, are they also -- do they also prepare the financial statements for Urology --

DR. COHEN: They do. They have been the

13:52:46 company's outside accountant since the company was formed in 1985.

MEMBER HAYES: And they've also advised and consulted on this transaction?

DR. COHEN: Yes.

MEMBER HAYES: They prepared financials, and they do the consulting on the transaction, as well as a valuation report?

DR. COHEN: Correct. And I mean, I will 13:53:00 confess I am no valuation expert, and that's why I feel comfortable in hiring and retaining those folks to handle that for me.

MEMBER HAYES: And going forward they will be the -- for the surviving entity, Shockwave, 13:53:16 they will also be the accountants for them, as well?

DR. COHEN: Absolutely.

MEMBER HAYES: All right. Thank you.

CHAIRPERSON OLSON: Questions or comments from the Board.

13:53:25 (No response.)

CHAIRPERSON OLSON: Seeing none, I'll ask for a motion to approve Project 14-005, United Urology Center LaGrange to effect a change of ownership at it's specialty ASTC in LaGrange.

13:53:41 MEMBER BURDEN: So moved.

MEMBER HAYES: Second.

MR. ROATE: Motion made by Dr. Burden, seconded by Mr. Hayes.

Mr. Bradley.

MEMBER BRADLEY: Yes.
MR. ROATE: Dr. Burden.
MEMBER BURDEN: Yes.
MR. ROATE: Senator Demuzio.
13:53:56 MEMBER DEMUZIO: Yes.
MR. ROATE: Mr. Hayes?
MEMBER HAYES: Yes.
MR. ROATE: Chairwoman Olson.
CHAIRPERSON OLSON: Yes.
13:54:07 MR. ROATE: Five vote in the affirmative.
CHAIRPERSON OLSON: Motion passes.
MR. COHEN: Thank you.
CHAIRPERSON OLSON: Next, we have
13:54:08 Applications Subsequent to Intent to Deny.
Project 12-096 Silver Cross Emergicare Center has been withdrawn by the applicant.
Then we have 13-050, DaVita Chicago Ridge Dialysis.
13:54:54 (Three witness duly sworn.)
CHAIRPERSON OLSON: State Board agency staff report.
MR. CONSTANTINO: Thank you, Madam Chairwoman.

The applicants are proposing to establish a 16-station ESRD facility in Worth, Illinois. The cost of the project is approximately $3.4 million. Board staff notes this application received an intent to deny
13:55:15 at the December 2013 State Board meeting.

On November 13th, 2013, the applicants submitted a Type E modification. On December 20th, 2013, and February 18th, 2014, the applicant submitted additional information in response to the intent
13:55:34 to deny.

There was no public hearing and no opposition letters received by the State Board staff. However, there were two findings. The first finding related to -- both findings relate to the facilities -- 19 of
13:55:50 the 33 facilities within 30 minutes are not at the target occupancy of 80 percent.

Thank you, Madam Chairwoman.

CHAIRPERSON OLSON: There were no letters of opposition?

13:56:05 MR. CONSTANTINO: There was no public hearing and no letters of opposition.

CHAIRPERSON OLSON: Comments for the Board?

MS. DAVIS: Yes, thank you.

My name is Penny Davis, and I'm the division vice president for DaVita in the Chicagoland area. With me is Dr. Sreya Pallath, who is our medical director for this proposed facility and our joint
13:56:32 venture partner, along with one of her partners, Dr. Michael Arvan. Also with me is Chuck Sheets, our attorney.

I'd like to thank those of you who voted in favor of this project when we came before the Board
13:56:48 previously.

As you know, it's a 16-station dialysis facility located on the border of Chicago Ridge and Worth, and it's a joint venture with our physician partners, a young group of physicians who have grown
13:56:59 their practice substantially over the last 10 years and who we believe provide the highest level of quality. DaVita has what we call our JV commandments. Our commandments mean that we have to work with physicians who are dedicated to quality outcomes and developing a
13:57:18 facility that provides the highest level of care for our patients.

Another part of this project is that we're going into an abandoned Aldi's building that would allow us to bring economic development to the area of

Chicago Ridge and Worth. Interestingly, the parking lot is in Chicago Ridge, and the building is in Worth. So that's why the confusion on the name.

I would like to address the concerns that you
13:57:49 brought forth regarding existing facilities at the last meeting.

The Chicago Ridge geographic service area is underserved compared to the rest of the state. 17,205 ESRD patients, or 27 percent of all ESRD
13:58:09 patients in the state reside within the Chicago Ridge geographic service area. However, only 15 percent of the approved patients, or 624 are located within this GSA.

As of December 31 of 2013, utilization of
13:58:26 existing or approved facilities within the area was 71 percent. This includes NxStage Oak Brook, which was approved at the December board, and three facilities that have been operational for less than two years, FMC Oak Forest and FMC Cicero, and our Lawndale Dialysis
13:58:49 which was approved on 12/10 of 2012. Speaking for Lawndale, I will mention that we became CMS-certified in January of this year and currently within a month's time has 10 patients. So it's growing rapidly.

NxStage Oak Brook, which will be providing

respite and health care dialysis, should not be included as it is not operational and will provide only respite and health care. Facilities in operation less than two years shouldn't be included in the analysis 13:59:25 because they serve very distinct patient populations and should reach target utilization by the second year after project completion. Accordingly, these facilities will not be able to accommodate Dr. Pallath and her partner's patients as they already have 13:59:42 patients that are committed as part of their project.

Removing these facilities from the average calculation means that the average utilization of existing facilities within the GSA is actually at 78 percent or just below the State standard. While we 13:59:59 recognize that many of these facilities are within 30 minutes of Chicago Ridge Dialysis, the majority of the projected patients reside in and around Oak Lawn. Therefore, not all the facilities within Chicago Ridge's geographic service area are really within 14:00:18 30 minutes of where the projected patients reside.

Requiring patients to travel more than 30 minutes for dialysis three times a week is excessive and does not meet the patients' best needs.

One thing I will mention is when we talk

about 30-minute time, we talk about travel by car. We also don't talk about travel in Chicago winters. Normally we have about a 6 to 7 percent missed treatment rate. We have seen over the last two months
14:00:53 approximately 10 percent missed treatments because patients could not get there, transportation was canceled, they couldn't get taxis, or they were just unable to get out of their neighborhoods.

The following facilities that are listed in
14:01:09 the report aren't viable options for Dr. Pallath's patients. Elmhurst, 30 to 50 minutes from where most of the projected patients reside. Mokena, 30 to 45 minutes for most patients. US Renal Oak Brook, 30 to 55 minutes. Markham Renal Center, which is less
14:01:33 than 30 minutes from where the patients reside is not also a viable alternative. We identified numerous issues with the facility when we acquired it from DSI two years ago. We received the Board's approval last March to relocate, and we anticipate that the
14:01:50 replacement facility which will open in July will achieve its target utilization within only 12 to 18 months. Taking into account all facilities that are not a viable alternative, facilities operating less than two years, outside of 30 minutes from patients'

residence in Markham, utilization actually increases to 81 percent, which is above the Board's utilization standard.

All three of our facilities that Dr. Pallath and her partners round at are at over 80 percent. On the list you'll see Westlawn at below 80 percent. Over the last two months it has since increased to 60, and it is now above 80 percent.

14:02:21

I'm going to turn over the presentation to Dr. Pallath who will speak about her patient base and issues with surrounding -- at the numerous dialysis facilities.

14:02:40

Also, in your packet I'd like you to reference the map which speaks to where Dr. Pallath's patients come from.

14:02:58

DR. PALLATH: Good afternoon. My name is Dr. Sreya Pallath, and along with my colleague, Dr. Michael Arvan --

MR. CONSTANTINO: We couldn't hear.

DR. PALLATH: And along with my colleague, Dr. Michael Arvan, I'm joint venturing with DaVita Healthcare for the proposed Chicago Ridge dialysis unit. I also will serve as the medical director for the proposed unit, and I wanted to take a

14:03:17

couple of minutes to explain why I'm partnering with DaVita for this unit.

My practice is very busy. We treat a combination of -- me and my partners -- we treat 14:03:47 967 patients with Stage 3, Stage 4 and Stage 5 kidney disease, and while we work with our patients to delay progression of the disease, unfortunately, many of them will progress to end stage kidney disease, or ESRD, within the next one to two years. In addition, we 14:04:07 treat 171 patients with ESRD who dialyze three times a week at the various centers.

I anticipate that our practice will get busier in the years ahead. According to the National Kidney Foundation of Illinois, over 1 million 14:04:24 Illinoisans have CKD and most do not know it. Often CKD is silent until the late stages of kidney disease when it's too late to head off kidney failure.

As more working families obtain health insurance through the Affordable Health Care Act, and 14:04:41 as well as 1.5 million Medicaid beneficiaries that transition from traditional to Medicaid managed programs, more individuals will be found to be higher risk, a lot of them low income African-American and Hispanic, and they will have better access to primary

care and kidney screening.

Based upon the U.S. Centers for Disease Control and Prevention, approximately 10 percent of American adults have CKD. Therefore, we anticipate 14:05:09 tens of thousands of newly diagnosed CKD in the years ahead as a result of the health care initiatives. These patients will be further along due to their lack of nephrologist's care prior to the diagnosis, and it is imperative that there is enough stations available 14:05:28 to treat this new influx of ESRD patients who will require dialysis in the next few years.

The majority of my patients live in Oak Lawn and the surrounding communities that include Chicago Ridge and Worth. Patients should be allowed to choose 14:05:50 where they dialyze, and to require these patients who suffer multiple comorbidities to travel 40 to 50 minutes to underutilized facilities in Elmhurst, Downers Grove, and Mokena does not meet the needs of these patients. Having the dialysis center close to the patient's home 14:06:13 is key. With excessive distances they frequently will miss dialysis units, and this results in involuntary noncompliance.

My practice is based in Oak Lawn, as I said, and so my office is easily accessible to most of my

patients. If my patients were required to dialyze, I would not be able to round to these facilities, and these patients would have to transition to another physician, and that would be disruptive to the
14:06:42 continuum of care, and the trust that they've developed with the relationship with them and their physician will be broken, and often they feel abandoned, and this leads to noncompliance with treatment.

Noncompliance has significant consequences,
14:07:01 things such as anemia and bone disease, because they're unable to receive the intravenous medicines in dialysis, fluid overload which would result in fluid in the lungs, the need for emergency dialysis and emergency room visits, cardiac complications caused by
14:07:20 high potassium that can cause cardiac arrhythmias, cardiac arrests, and death, as well as stroke. In addition, skipping dialysis has been shown to increase mortality. Skipping one or more dialysis sessions has been shown to increase hospitalizations by 16 percent
14:07:41 and an increase of 30 percent in mortality compared to those who do not miss dialysis sessions.

I'm partnering with DaVita on this unit because of DaVita's reputation for excellence. DaVita has the lowest mortality rate of any large dialysis

center. DaVita also has the lowest capital rates. DaVita is also the largest home hemodialysis provider in the United States, and we will be providing home hemodialysis, as well as peritoneal dialysis training
14:08:16 programs at the Chicago Ridge unit.

DaVita is committed to offering alternative modalities compared to traditional in-center dialysis, and that is an aspect that's very important to myself and my colleagues. Our practice is committed to
14:08:33 providing alternative modalities that include home hemodialysis as well as traditional dialysis to ease the stress and the burden of dialysis on my patients.

Patients on home modalities do not have to travel to a dialysis center three times a week, and
14:08:49 this is very important for my elderly patients who often require special transportation support. We meet with these patients once a month to monitor their medical condition and to determine if there's any changes needed to their dialysis prescription.
14:09:06 Additionally, they can control when and how to dialyze.

Other aspects of DaVita that I do find very important is the DaVita RX program, which is a full-service pharmacy program that helps hemodialysis patients well as home dialysis patients to manage their

prescriptions. The DaVita RX program provides extensive drug reviews on prescriptions to ensure you that they're not being prescribed drugs that they're allergic to or should not be taken together. These
14:09:39 prescriptions are delivered to the patients' homes at no cost to them. They receive weekly reminders of what medications are needed, and this is an invaluable resource for many of my patients who require multiple prescriptions and medications for their dialysis as
14:09:57 well as their other comorbidities.

In addition, kidney disease education is something I find very important, too, and DaVita provides a free education program called Kidney Smart to provide patients with information on kidney disease
14:10:13 and on dialysis and other treatments for kidney failure.

Finally, I wanted to emphasize the importance of educating these patients on other treatment modalities such as transplants. I counsel my patients
14:10:27 on all modalities, including transplants, from the first encounter, and we encourage all of our patients to go for a transplant evaluation. In fact, I'm on the medical staff at Advocate Christ Medical Center which is located less than half a mile from my office, and

they do provide transplant services. And I work with a transplant team before and after transplant to monitor their medical conditions closely and feel this is a very important aspect of their care.

14:11:01 Unfortunately, there is a shortage of available kidneys. There are currently 4,588 individuals in Illinois waiting for a kidney transplant, and, additionally, many of these patients are ineligible to receive a transplant because of their multiple

14:11:18 comorbidities. So while we encourage patients to utilize these alternative treatments, we understand that many patients are much more comfortable in a treatment center where they feel they have better treatment, and, therefore, facilities like Chicago

14:11:31 Ridge are necessary to serve the increasing number of ESRD patients.

So in conclusion, I'd like to thank you and ask that you approve this project for the Chicago Ridge unit to allow myself as well as my partners to provide

14:11:48 this important hemodialysis center to my patients.

Thank you very much.

CHAIRPERSON OLSON: Thank you.

Any questions from the Board?

(No response.)

CHAIRPERSON OLSON: Actually, I want you to help me out here. I was trying to follow you, and I was having a little bit of trouble.

I'm looking at pages 2 and 3 of the State 14:12:09 Agency report because the one negative finding is the utilization of the facilities in the area that are not at capacity.

So I want you to help me go down this list because I think you had some problems with the list the 14:12:23 way it was. So Crestwood, that's closed.

MS. DAVIS: Right. Actually, Crestwood and Direct Dialysis. Direct Dialysis is actually at 95.4.

CHAIRPERSON OLSON: So that's 95.4, so 14:12:41 that meets -- can you agree with that or no?

MR. CONSTANTINO: Yes.

CHAIRPERSON OLSON: So Crestwood is at 77.78; correct?

MS. DAVIS: Yes. Crestwood is 14:13:11 approximately 75 percent.

CHAIRPERSON OLSON: Alsip you've got at 65.8.

MS. DAVIS: They can only accommodate 16 additional patients at this point.

CHAIRPERSON OLSON: Palos Park is at 36. Now, I think you said something about that. What did you say?

MS. DAVIS: Palos -- actually the 14:13:30 physician that is their medical director there had previously been a physician at Christ. She has moved her practice down to Palos Hospital, and so her patients are not coming from the Oak Lawn area; they're coming from the Palos area.

14:13:44 CHAIRPERSON OLSON: But is she taking new dialysis patients or no?

MS. DAVIS: Yes. In fact, that facility just in the last month has added three more patients. So they're growing rapidly.

14:13:58 MR. CONSTANTINO: Madam Chairwoman, we have to rely upon the most recent data we have.

CHAIRPERSON OLSON: I understand.

MR. CONSTANTINO: We did make a mistake on the one facility, but the rest of the data we relied 14:14:09 upon what they provided to us. I can't refute anything that Penny is saying, and I don't know if it's true or not.

CHAIRPERSON OLSON: That's fine. I guess the only other thing I want to ask you is, I'm

trying to understand your argument about how we can't count facilities that are new. It seems to me those are the ones we really count because they need the patients. I'm not following that logic.

14:14:36 MS. DAVIS: For instance, when we did our application for Lawndale -- and Lawndale is less than two years -- we assumed -- and I think you remember Dr. Aneziokoro -- that he had enough patients and he certified that he had patients that would bring

14:14:51 that to 80 percent occupancy within two years. Those are separate patients from what we're talking about in terms of Dr. Pallath's patients. So the Lawndale facility already has technically patients committed to it from another physician.

14:15:08 CHAIRPERSON OLSON: But couldn't you make that argument about every one of these? Because we only approved them because they said they were going to meet target occupancy in a certain amount of time.

MR. SHEETS: Madam Chair, maybe I can

14:15:23 address that. Unlike other health care providers that come before the Board, these particular units are strictly built up by physicians that go there. So it's a physician practice-driven model.

So when a patient is a patient of a certain

physician, in order for them to go to a different facility, many times they would have to switch physicians because the physician doesn't round at that facility. And here we have that similar situation
14:15:52 because we have certain physicians that are out of Christ Hospital, which is up in the northeast corner of the area, and then other physicians that you're talking about that have patients out of Palos Hospital, which is in the southern tip of the area. So, in other
14:16:07 words, the patients would have to shift doctors, and we found that that just doesn't happen. I mean, they're not comfortable changing physicians.

CHAIRPERSON OLSON: So is that an explanation then for why -- because I'm a little bit
14:16:18 surprised when there's 17 facilities that aren't at target utilization there's no letters of opposition. Is that because they have their patients so they don't care if another facility is open?

MR. SHEETS: I think that's true. I
14:16:33 also think there's a ramp-up based on the disease and how it progresses that's unlike other models, also. So we have these pre-ESRD patients and patients that get into ESRD, and there's a time frame that I'm sure Mike can address much better.

CHAIRPERSON OLSON: Dr. Burden.

MEMBER BURDEN: I don't want to interrupt you, Madam Chair.

CHAIRPERSON OLSON: This is your area.

14:17:00 MEMBER BURDEN: Well, it is and it isn't. I want to know in simple terms -- Penny presented a lot of data. For an older fellow it's hard to put it all together.

What's really happened in two months? We

14:17:14 were at eight people here; now we're five. One no doesn't allow a lot of wiggle room. So I'm going to ask, we had two yeses and five noes at your last appearance which was just two months ago, and there was a lot of discussion about the wonderful talents of

14:17:33 current nephrologists of whom I know about 200, and they all feel pretty talented; they're board certified and working and do a great job, and I relied on a lot of them for urological issues. So what's changed?

MS. DAVIS: What's changed is the fact

14:17:47 that at the last meeting there were no questions by the Board, which I always hope for because then we're actually able to explain without pointing out every single detail.

But there were some errors in terms of some

of the facilities in the last report showing transposed numbers. So one that was like 39 percent -- I think it was Evergreen Park -- which was actually at 90 percent. So there were some -- I think the data is better now
14:18:18 that we've been able to -- we submitted additional information regarding that data. We still have a huge number of patients.

This is a project that -- I mean, when we did this map, the reason we did this map is because we've
14:18:37 gone through this winter, this last four months of winter, and 15 minutes is a heck of a lot of transportation time for a patient on dialysis. So by creating this and showing you that Dr. Pallath's patients come from this area that surround Chicago
14:18:56 Ridge, because it's on the border of Oak Lawn, that we really believe that the need is there. We've got the patient numbers. There's been utilization numbers corrected. It just continues to show that the dialysis patient population continues to grow.

14:19:22 MEMBER BURDEN: We hear that every time Sheets shows up. There's no question there's not going to be enough dialysis facilities available, that there's an immense number of unenlightened people who have failed to have a regular checkup and don't find

out they have protein their urine until they're ready to explode.

I want to know from personal attitudes that this application is really directed towards patient
14:19:47 convenience. In all due respect, Doctor, if you have to travel further, I don't give a damn. I do care about the patients. I've had a lot of nephrologist buddies over the years that used to complain to me, "God, I've got to drive here." That's too bad. I
14:20:04 mean, I am worried about the patient travel, not yours. That's my feeling.

Now, I've heard an explanation that part of this is more convenient for you. That's not the selling to me. A selling argument is if your patients
14:20:17 are really in a situation where they've got to travel a terrible winter -- I would imagine everyone that has been out in the snow -- I haven't been, thank God. I've been out of this climate for the last four months and I didn't miss it.

14:20:34 You've got to sell me on that. I hear you. You're doing a pretty good job, but is this really -- I think others on the Board are probably more succinct. I'm looking at the practicality of making this available for people in bad weather, good weather, not

for the doctors to make rounds, which they do make diligently at midnight or 1:00 in the morning in order to fulfill their commitments of being good doctors. I'm fully prepared to say that that's what I always
14:20:59 heard when I knew damn well that they weren't there at 1:00 in the morning unless there was something going on.

But I'm kidding. I don't mean to be -- I don't mean disrespect. This is comment about patient inconvenience. I'm not too impressed about doctor
14:21:12 convenience. That's me.

DR. PALLATH: I totally agree with you. My patients are my priority, and I have no problem if my patients do not want to come to my -- come to where I go, and I tell them right away there are places --
14:21:29 wherever you want to go, wherever you choose to go to dialyze. I agree with that.

The fact of the matter is, however, that given my location base, where I'm located, which is less than half a mile from Advocate Christ, the
14:21:43 majority of patients come through there. All my referral base is in this area. So the fact of the matter is the majority of my patients do, in fact, live in this area, and they do want to dialyze very close to their area.

That is why I feel like we are having difficulties a lot of times placing our patients. When I see patients in the hospital and I have to apply for a place, a lot of times they have to go to a temporary
14:22:11 dialysis unit further away from where they really live until a chair or a bed becomes available at a unit that's closer to them.

I agree with you that the patient's ease is the most important.

14:22:26 MEMBER BURDEN: I just want to ask how come 19 of 33 facilities back December that they're all changed in two months, that they are within 30 minutes and not operating at 80 percent. You described about facilities that were not available. The data says
14:22:43 something else.

I'm not trying to be argumentative. Did you solve that issue? Did you convince us that this indeed is erroneous?

MS. DAVIS: The issue in terms of
14:22:57 dialysis, and I believe every provider would say the same thing, is it's about patient choice. So we want patients to go where they want to go. Even when we have programs in hospitals we don't refer to our own facilities because patients under -- the code of

conduct in our industry is patients in the hospital, now they have to go to dialysis, they're given a list of dialysis facilities in their community and closest to their house. If they don't have one close to their
14:23:31 house and they want still to see Dr. Pallath, then it's not available, a station is not available.

The one closest to Christ Hospital is our Stoney Creek facility, and I think on the utilization report you have is 98 percent. So that's the facility
14:24:04 closest to Christ where the patients go, where their physician practices and it's full. And to ask them to travel -- you know, when I lived 30 minutes -- I drive throughout Chicagoland every day, and I've not come to the Board ever asking for a facility in a GSA or an HSA
14:24:28 that had an excess of stations. There are stations necessary. We know that the patients reside in this community and they deserve it.

I have watched patients who drove to their dialysis trying to park on the street but the street
14:24:45 was a snow removal street in Chicago, and they couldn't park and had to walk three and four blocks to park on a side street. We've watched that. We have seen patients who show up an hour late for dialysis because they couldn't get transportation. The transportation

probably got stuck in the snow.

If it's closer to them and if they really have health care in their neighborhood for -- this isn't once a month go see your doc; this is three times
14:25:19 a week for 12 to 15 hours these people are in these facilities. So having it close to home and in an area that really does have a need for dialysis based on the State's standards -- you know, I think any of you who know the city of Chicago to be able to say that -- you
14:25:47 know, to go to Mokena from what is really an area not far from Midway, it's at 95th and Harlem, to go down to Mokena, that's an hour. Based on MapQuest it's 30 minutes. I think MapQuest is built on 3:00 in the morning when there's never a car on the road.

14:26:18 MR. SHEETS: I've been waiting for this because Dr. Burden asked the question. We keep talking about the map. The map is the second-to-last page of the report, and because we wanted to show you it was convenient for the patients, all the little red dots in
14:26:35 the map with numbers in them are the zip codes of where the patients reside who'd go to this facility should you decide to approve it.

So I think we're pretty centrally located within where these patients reside. In fact, that's

why this location was selected was so that it would be centrally located to where those patients are that the doctors project would come to this facility.

MEMBER BURDEN: Mr. Sheets, your argument is getting to me -- okay? -- I understand. I can't see the little red dots on this copy, but I presume I don't have to walk over and see your copy. I do know where this areas is located, and I am sensitive to the patient transfer.

14:27:20 Thank you.

CHAIRPERSON OLSON: Any questions or comments from Board members?

(No response.)

CHAIRPERSON OLSON: There being none, I'll entertain a motion to approve Project 13-050 DaVita Chicago Ridge Dialysis 16-Station ESRD.

MEMBER BRADLEY: So moved.

MEMBER BURDEN: Second.

MR. ROATE: Motion made by Mr. Bradley, seconded by Dr. Burden.

Mr. Bradley.

MEMBER BRADLEY: I concluded at the last discussion that this would improve access and still believe that, so I vote yes.

MR. ROATE: Thank you.

Dr. Burden.

MEMBER BURDEN: I didn't agree with Mr. Bradley on the last visit, but two months later I
14:28:02 think I have reached the point where I would be convinced that this was as absolute necessary. I vote yes.

MR. ROATE: Senator Demuzio.

MEMBER DEMUZIO: Yes.

14:28:15 MR. ROATE: Mr. Hayes?

MEMBER HAYES: I vote yes because of the utilization at the other facilities are -- many of them are near 78 percent or over 70 percent, and I also believe that patient access I think will be improved.
14:28:33 So I vote yes.

MR. ROATE: Thank you.

Chairwoman Olson.

MEMBER OLSON: Well, I'm having a hard time because I believe if I vote yes on this, I
14:28:42 have to vote yes on every facility that comes in and there's facilities in the area not meeting capacity. I'm trying to follow your argument. I understand, Doctor, but there's that same argument for every single ESRD. They're all in need; they all have the patients;

they're all going to be at capacity.

I have to vote no. Otherwise, I have to vote yes on every one that comes before us, and at this point I can't in good conscience do that. When is 14:29:10 enough enough?

MEMBER BRADLEY: In the world of selling gasoline, there are a couple of big competing for-profit companies in the area, Mobil and Exxon on one side and Shell on the other.

14:29:23 MR. CONSTANTINO: Mr. Bradley, can you speak in the microphone?

MEMBER BRADLEY: They try to locate their facilities where there's people who buy gasoline, and the market says whether they make money or not, 14:29:35 whether they stay in those neighborhoods or not.

I think that what we're seeing in this industry is competition, and if what is approved is not successful, the for-profit company will close it.

But this is not like building a $200 million 14:29:58 hospital. The entire operation here may cost 4 or 5 million, and it's a risk they take. And I think that having adding it on in the community with the access that they provide is a worthwhile thing.

CHAIRPERSON OLSON: I respect your

opinion. I don't change my vote.

MR. ROATE: Thank you, Madam Chair. That's four votes in the affirmative, one vote in the negative.

14:30:25 MR. URSO: You're going to be receiving a denial and an opportunity for administrative hearing if you request. Thank you.

(Recess taken, 2:31 p.m. to 2:37 p.m.)

14:37:54 CHAIRPERSON OLSON: We have at the table Aegean.

(Four witnesses duly sworn.)

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

14:38:12 MR. CONSTANTINO: Thank you, Madam Chairwoman.

The applicants are proposing to establish a 110-bed skilled care facility in Lockport, Illinois. The total cost of the project is approximately 14:38:24 $26.9 million. This project was given a board deferral at the November 5th, 2013, State Board meeting and an intent to deny at the December 17th, State Board meeting. This project was deferred from the January 28th, 2013, State Board meeting which was

subsequently canceled because of poor weather.

The applicants modified this project on January 17th, 2014. This was a Type E modification, and the applicants addressed 20 criteria and did not
14:38:58 meet planning area need -- there's in excess of 169 beds -- service access, unnecessary duplication of service, and reasonableness of project cost.

There was opposition letters and support letters were received by the State Board staff. No
14:39:16 public hearing was held.

Thank you, Madam Chairwoman.

CHAIRPERSON OLSON: Comments for the Board?

DR. ROUMELIOTIS: Yes. I don't know if
14:39:26 you can hear me very well. My name is Peter Roumeliotis, and this is my wife Patty, we're both the co-owners; Ed Green from Foley & Lardner; and John Smith, who is the CFO of Revere Healthcare, who is our consulting firm.

14:39:49 Initially I had a whole big document I was going to read to you, and last night about 10:00 at night my wife told me, she goes, you know, "Why don't you just talk from your heart." So what I'm going to do right now is I'm going to talk from my heart and lay

it all on the line. They say behind every good doctor is a very great nurse, and I'm going to follow her.

So my name is Peter. I'm a practicing physician, internal medicine. I've been practicing for
14:40:26 over 20 years. I have a private practice, a hospital practice, I'm medical director of three skilled nursing facilities, three home health care agencies, and two hospices. I'm also a supporter of Will-Grundy Free Medical Clinic since 1994 both professionally and
14:40:47 financially. I volunteer my services to them for -- since 1994 seeing patients in both Grundy County and the Joliet area, basically providing free care for them.

AegeanMed Health Care is located on a 9-acre parcel at 167th and Prime Boulevard just east of I-355
14:41:17 in Lockport. It's approximately 4 minutes away from the new Silver Cross Hospital, 7 minutes away from the new VA clinic, and about 15 minutes away from the Adventist Bolingbrook Hospital.

Our intent first and foremost is to serve the
14:41:36 needs of the local community of Lockport. AegeanMed will be providing rehabilitation services that no skilled nursing facility in the area provides. Our primary focus will be those motivated patients that are willing to participate in up to six hours of therapy.

I expect that our population will be much younger than the typical skilled nursing or nursing home patients that you see.

The first thing is ours is going to be a
14:42:04 transitional care center. I know this is sort of like new terminology to this Board. What's the difference between the typical skilled nursing facility and our transitional care center? AegeanMed is not proposing to construct a typical skilled nursing facility nor is
14:42:25 Aegean proposing to construct a typical general acute hospital. Instead AegeanMed is proposing to construct a transitional care facility that will specifically target the population of patients discharged from general acute care hospitals that need a level of care
14:42:42 between a typical skilled nursing facility and a general acute care hospital. These types of services are called subacute services or transitional care services.

Our typical patient will need anywhere from
14:42:58 one to six weeks of intensive rehabilitation services. The goal is to rehabilitate the patient so they do not have to return to the hospital with the ultimate goal of them returning home to be with their family. Patients will benefit both physically and

psychologically.

Skilled nursing facilities and especially transitional care centers work differently than hospitals and use different staffing models. Our
14:43:30 AegeanMed health care model will take advantage of nurse practitioners, and this is something new where we will be able to deliver a higher level of care that cannot be addressed by the registered nurses or LPNs. We will also have a higher ratio of registered nurses
14:43:49 and LPNs due to the severity of illness of the patients that we expect to follow.

Our facility will operate like a subacute unit of a hospital and will deliver a higher level of nursing care, a higher level of physician involvement,
14:44:05 a higher level and more intense level of rehabilitation care, and will generally cater to the most acute patients.

How many times have you visited a nursing home or a hospital and you see the patients, they'll
14:44:21 get one or two hours of therapy per day, and then they sit around for 22 hours after that? What we're proposing is a transitional center where patients will receive up to six hours of therapy. These are going to be highly motivated patients that want to get better

sooner and get back home.

If we cannot help these patients in the six-week period that is what we consider our maximum, we will be referring those patients to other skilled
14:44:57 nursing facilities in the area to continue their care. So our goal is to get patients home sooner or get them to the appropriate place as soon as possible. This form of specialized care is clearly outlined in the Affordable Care Act.

14:45:16 I personally employ three nurse practitioners. At one of the skilled nursing facilities that I am medical director, I've made them available during business hours. We have increased the 30-day readmission rate in the State of Illinois from an
14:45:33 average of 26.9 to 15.6. That's an improvement of 58 percent. We have also decreased the 30-day mortality rate in this facility from 12.3 percent to 5.6 percent. So this nurse practitioner model works.

How does this work? Right now if a patient
14:46:01 is ill and they're at a rehab facility, the knee-jerk reaction is for the nurse to contact the doctor. And what does the doctor do? The doctor tells them to send them to the emergency department. Every time that they send a patient to the emergency department an ambulance

ride alone costs $700 each way. So that's $1400 right there just for transporting the patient back and forth to the hospital.

If you have a nurse practitioner that's
14:46:35 on-site, they will be able to evaluate the patient; they will actually contact a physician; they can write orders unlike a registered nurse. They will be able to take care of a patient on the spot and start treatment sooner and prevent these rehospitalizations and these
14:46:56 trips back to the emergency department.

In 2010 in Illinois the average cost of hospitalization was $2,049 per day versus $152 a day for a skilled nursing facility. If we can take those patients one day sooner, the amount of money that will
14:47:18 be saved -- a patient can spend 12 days in a skilled nursing facility versus being in that hospital for that one extra day. So how much care can you actually give these patients, and how much money can you save by treating patients sooner and moving them to these
14:47:40 facilities quicker.

With more intensive therapy treatments patients will go home sooner, again reducing costs, and we must reduce the hospital readmission dates especially in the first 60 days.

We also plan on working seven days a week. Okay? How many times in the hospital you have patients that go there Saturdays and Sundays, everything shuts down, "We'll wait until Monday" to do a stress test, to 14:48:11 do anything. We plan on doing therapy, treatment, full day, seven days a week, get these patients where they need to be sooner and faster.

What makes us different? The types of therapies we're going to offer. We are planning on 14:48:30 installing Hydroworks hydrotherapy with an underwater treadmill for traumatic brain and spinal cord injury patients, as well as nonweight-bearing and partial weight-bearing patients. How many times have you seen patients that have had, for example, hip replacements, 14:48:47 knee replacements, and then they have to be offloaded for six weeks. With this hydrotherapy you're actually taking off the burden on their joints, and they would be able to participate in therapy instead of just sitting around for six weeks.

14:49:04 We plan on having an in-house automobile. We need to train these patients, when they go home, how are they going to get their groceries in the car; how are they going to get their wheelchairs, their walkers -- we're actually going to have an automobile

in the facility, not outside, where we can train these patients to put their groceries in the trunk, things like that. Those are services that are not offered by any other skilled nursing facility in the area.

14:49:36 We plan on working with amputees, get them prostheses, get these people rehabbed sooner. The wounded warriors, how many times you have these wound warriors that are coming from Afghanistan and Iraq, and they need high levels of care, and they just want to

14:50:02 return to their families or return to their battalions. These are the types of people that would participate in intensive therapy and be able to get home sooner.

What about a mother who has a ruptured brain aneurysm who is highly motivated and anxious to return

14:50:22 to her family and kids? Those are the types of people we don't want them sitting around doing therapy for one to two hours a day. These are the people that are going to be highly motivated so they can get home as soon as possible.

14:50:40 Patients on ventilators. Traditionally these patients we see with pneumonia or COPD or emphysema or asthma, they'll be on ventilators and need to be weaned and stay in the hospital for a week or 10 days to get weaned off the ventilators. There's no reason why a

person should have to stay in the hospital to have a weaning procedure done when it can be done so much cheaper and so much more efficiently, cost effectively in our facility.

14:51:07 We plan on doing specialized wound care treatment, including bioengineered skin grafting. It's a new thing for people that have deep wounds, and these actually do not need to be done in a hospital setting. Some doctors are now doing these in an office setting.

14:51:27 So you'll be able to heal these wounds in this setting intensively and get them home faster.

IV nutrition. I'm not talking just IV fluids; I'm talking about people that, for example, have acute pancreatitis, malabsorption syndromes like

14:51:43 Crohn's disease, different malignancies like head and neck cancers and esophageal cancers who will be unable to eat or drink for a finite period of time. Right now those patients are staying in the hospital or going to a subacute hospital care setting because there's no

14:52:01 skilled nursing facility that will take care of those patients. We want to take care of the high intensity, high acuity patients because we feel that there's a need for, and it's not being done anywhere, and it would definitely help save costs.

The other thing that we plan on doing is having the patients' families participate in their care, train the patients' families so when they do go home, they will be able to help them, and we would also
14:52:34 help provide outpatient services for them so they could follow up in the meantime and continue their rehab after they go home.

One of the major issues that is brought up as a deficiency is a need in the area.

14:52:51 We did not choose the Lockport site randomly. We performed a market analysis and feasibility study for the project over two years ago. At that time there was a calculated need for 629 beds in Will County. Approximately five to six months ago an updated study
14:53:10 was published based on 2010 data that showed a surplus of 149 beds in Will County, which I assume was due to the downturn in the economy at the time. This was also prior to Silver Cross Hospital opening in New Lenox two years later in 2012, and that's 3 1/2 miles east of
14:53:32 the old campus in Joliet and only 3 miles away from our new facility. There is not one skilled nursing or nursing home facility in the entire city of Lockport. That's unheard of. There's no other facility.

If you listen to Ben Benson who is the City

administrator for Lockport today, they expect huge growth in that area coming up. They have over 450 single-family homes that are -- new homes that are expected to be built in Lockport this year alone. So
14:54:12 there's a huge growth, and there's definitely a demand for it.

I would also like to remind the Board that our facility won't be open for another two, three years of construction. So we expect further growth
14:54:27 especially if you believe that the economy is turning around, which is clearly happening.

At this point I think I will -- we plan on having approximately 110 to 120 permanent new jobs. There will be the creation of approximately 250 union
14:54:52 construction jobs for this project with 22 different skilled trades craftsmen and 60 different unions in the region.

I can't thank you enough for taking the time out of your busy schedules to consider our project of
14:55:07 AegeanMed Healthcare. By approving AegeanMed Healthcare's request for certificate of need, you will be influential in raising the standard for cost effective quality-driven transitional skilled care in Illinois.

Steve Jobs said the people that are crazy enough to think they can change the world are the ones that do. With your help I hope to be one of those crazy people.

14:55:32 CHAIRPERSON OLSON: Questions or comments from Board members?

Doctor.

MEMBER BURDEN: As usual I have a comment to make.

14:55:39 Doctor, that was an eloquent presentation. It came from the gut and I am impressed. You certainly put it together very clearly what you want to do.

You're selling yourself as a unique institution, obviously, presenting many, many topics

14:55:52 that we don't hear very often. I suppose it's fair to say if we do approve your application, I would submit that we'd love to have a follow-up on it because we're unable -- I'm unable to tell you how I feel about some of the things you're presenting. Wound care, for

14:56:10 example, I know plastic surgeons who would rather fix a body part and make it look prettier than deal with vascular insufficiencies, all the problems that need wound care treatment. That's a very neglected area. I've been away from the private practice for 13 years,

but it was a problem then and I don't suppose it's gotten any better.

But we're facing something that you know. I mean, there's clearly evidence there's need for your
14:56:38 facility. You want us to understand that you're now selling what you present, and that is something we have to -- a hypothesis. There's no evidence that I see other than your word, and that is a problem.

But it is something that makes me say,
14:56:54 perhaps this is something innovative, worthwhile to consider, but I would want to see some data down the line. I mean, you're not going to be ready to roll until October 2017. I may be one -- I may not be around. You'll say, "That guy's not around. He's
14:57:11 buried." But you understand what I'm saying.

I think it's admirable; it's innovative; these are things we should be interested in, obviously. But, also, it's hard to buy something without some evidence other than your word. I mean, there's no
14:57:27 track record. You're presenting it as, "Look at me. I'm articulate, hardworking; I've got a good looking wife who's going to keep track of me and make sure I do what I say I'm going to go do." That's fine but I guess maybe my attitude would be we'd like some proof

of this. And that would mean for an approval from me I would want when you're building -- and that's a long way off -- you ought to be able to send that to us and say, "Hey, see what I've done; watch what I've done."

14:57:52 I don't know. I hear what you said. This is the second time you've been here. Back in November you had some support here but now we're just five. You're here in front of five people. One no and you're home again wondering, "What am I going to do now to sell

14:58:08 this project?"

So I'm careful about when I say if you get a positive vote, my opinion would be there ought to be something in it that makes us aware we can prove that we were right with you. That would be a long way down

14:58:23 the line.

That's enough. Thank you very much.

MR. CARVALHO: Good afternoon. I don't say this very often, but there's several things about this application that really bother me. And I didn't

14:58:49 talk about it with my wife last night, but I asked myself why, and so I hoping I'm misunderstanding some of this. Because if I'm not, it's troubling the way you packaged this application.

First, how will this be licensed? Will it be

licensed as skilled nurse beds or as immediate care?

DR. ROUMELIOTIS: This is licensed as skilled nursing.

MR. CARVALHO: That's one of my

14:59:15 problems. A skilled nursing bed -- well, anybody in a skilled nursing facility is supposed to receive care dictated by their condition. So when you say because you're going to have more acute people you're going to provide a higher level of care, that's not out of the

14:59:34 goodness of your heart, that's a requirement. If you have more acute people, you have to provide a higher level of care.

Secondly, the model that most what we call nursing homes in the state have is a mix of skilled

14:59:51 nursing beds and intermediate care beds. And we all know unlike many states -- Bill was just telling me one of the things we're learning is that in Ohio the Medicaid rate for skilled nursing and intermediate care is pretty comparable. But we know Illinois has a

15:00:08 terrible -- sorry, Mike -- but terrible reimbursement rate for Medicaid. So the model that keeps nursing homes in business is that they have a balance between the two, and they probably lose some money on the Medicaid, but they make some money on skilled nursing.

If in the face of a bed excess of 169, whatever it is, your model of just focusing in on the highly reimbursed beds is permitted to go forward, you are destabilizing the model that keeps all the other
15:00:43 nursing homes in business, and if your model proliferates where people come in and just do only skilled nursing, we would really start wondering how people who are on Medicaid get services if the model that keeps homes and have a mix of business goes by the
15:01:01 wayside.

The reason why the bed need flipped from an excess of beds to -- a need for beds to an excess of beds wasn't because simply of a population update. Also, there was a really dumb law in place that said
15:01:17 for our projections we were supposed to look 10 years out rather than 5 years out. That was put in for a particular reason, to help a particular hospital at a particular location, and it was dumb at the time and it got fixed. So that flipped the numbers throughout the
15:01:33 state. So it's not that -- we were overstating need under the old model, and now we have something more accurate because it does not take 10 years to build a nursing home, and it was silly to be using 10 years as a model.

The fact, again, because you said you're going to be providing more staffing, that's an obligation. So some of the observations that Dr. Burden made about the mission that you've set out for yourself, at the end of the day you're still going to be licensed as a skilled nursing facility, and your CON would be a skilled nursing facility, you would have no obligations to do more than a skilled nursing facility, and if just for whatever reason you started accepting lower acuity persons, that would be entirely consistent with your CON, entirely consistent with your license, and then this destabilization of the economic model throughout the state.

So all of those things were what led to my unusual visceral reaction to this. Have I misunderstood something? Because I'm fully prepared to say, "Oh, never mind. I misunderstood" but I need to hear why.

DR. ROUMELIOTIS: Well, the first thing is that you're assuming that we're not going to be taking public aid.

MR. CARVALHO: I'm assuming you're not going to be taking intermediate care.

DR. ROUMELIOTIS: I don't understand

15:02:06 15:02:26 15:02:40 15:02:52

what you mean by "intermediate care."

MR. CARVALHO: When people who come out of a hospital -- it's easier to think of it in terms of the Medicare population because it's so obvious.

15:03:15 Medicare covers the step-down care that you need in a skilled nurse facility after an operation where you're no longer appropriate to be in a hospital but you aren't ready to go home, but it doesn't cover if you're just unable to -- what's the phrase -- unable

15:03:34 to do two or more of the activities of daily living. That's intermediate care.

So to put it in colloquial terms, when our grandmothers go in nursing homes because they can't live alone, that's intermediate care. When our fathers

15:03:53 get out of heart surgery but aren't ready to go home, that's usually skilled nursing care. So we -- at least for purposes of reimbursement, for purposes of licensing there are different standards under the licensing rules for those two types. So we make that

15:04:13 distinction between skilled nursing and intermediate care beds. For purposes of reimbursement there's a different standard, too.

That's what I'm alluding to. You're focusing on the skilled nursing side -- right -- but you're

calling it transitional.

DR. ROUMELIOTIS: That is the model now for the transitional care centers because you need to have critical pathways in place. You need to get these
15:04:35 people home quicker, and the way that you save money is not by having a person that goes in -- for example, you get an 80-year-old or an 85-year-old person that goes in and ends up spending six weeks or a couple of hundred days in a skilled nursing facility getting
15:04:54 rehab for, let's say a broken hip.

What we're focusing on is those patients that can get six hours of therapy a day and get home faster. Why should they sit in a facility for six weeks? That's where you're wasting resources, wasting money.
15:05:12 You can't put all of these different people in the same pool. What we want to do is we want to get the highly motivated people that are willing to put in the extra effort and get out faster, which is going to save us or the system overall.

15:05:27 MR. CARVALHO: Transitional care as you're using it is a marketing term. There's no license category; there's no reimbursement category. It's simply saying, "I'm going to take the skilled nursing license, and I'm going to elect to seek

patients who have this higher acuity," but if you were just a regular run-of-the-mill skilled nursing facility, and you called yourself transitional, and you've got somebody who needed six hours of therapy a
15:05:57 day instead of two, you would need to provide them six hours of therapy. You aren't allowed to not provide for your patients' needs.

So I don't understand how what you're saying isn't simply marketing as opposed to a medical model.

15:06:19 DR. ROUMELIOTIS: I just don't see that happening right now.

CHAIRPERSON OLSON: Mike, can I ask you a question? Because it seems to me like what we're talking about here -- and I understand that I think the
15:06:28 issue becomes that there's not a category --

DR. ROUMELIOTIS: We don't have a category.

CHAIRPERSON OLSON: We don't have a category.

15:06:34 I'm curious. It seems to me that they're almost describing a model that would be more like RIC or Marianjoy. How are those facilities licensed? I guess RIC is a hospital. Is Marianjoy, also?

MR. CONSTANTINO: Hospital, yes.

CHAIRPERSON OLSON: So because the precipitating event is not happening at your facility but they're being transferred to a facility, you would not fall under the category of --

15:07:02 DR. ROUMELIOTIS: Right.

CHAIRPERSON OLSON: What do you predict your average length of stay to be?

DR. ROUMELIOTIS: We expect it to be less than six weeks. I expect -- our goal is to get

15:07:15 them out in one to two weeks.

CHAIRPERSON OLSON: Other questions or comments from the Board members?

(No response.)

CHAIRPERSON OLSON: Seeing none, I'll

15:07:32 accept a motion to approve Project 13-048 AegeanMed Transitional Care Center of Lockport to establish a 110-skilled nursing facility in Lockport.

MEMBER BURDEN: So moved.

MR. URSO: Can I just say one thing?

15:07:47 CHAIRPERSON OLSON: Yes.

MR. URSO: Dr. Burden did talk about some kind of reporting condition. So I don't know if you want to include that as part of your motion.

MEMBER BURDEN: Well, I would like to

consider personally -- I can't endorse this for the entire Board, they have to think about this, but we're talking approval, if it is approved, we still have a time frame of at least -- almost three years or a
15:08:14 little more. We're talking October of 2017, which is another issue. I don't know why it's taking so long, but that's your target date.

CHAIRPERSON OLSON: So would this be information outside of what we would require on their
15:08:29 annual report?

MEMBER BURDEN: Well, I heard what David had to say regarding a skilled nursing facility and its obligations, and we're listening to an applicant who feels he can do a better job and it's something that
15:08:48 should be endorsed.

If we are and if he does it under a category without having a category -- if he's doing it within the category that we don't have the attitude of qualifying his particular facility, we ought to have
15:09:01 information demonstrating that we were correct in allowing this procedure to go forward.

Because we are in an area where there's an oversupply, an excess. The current participants in this field are not going to be ecstatic to hear that we

sort of went against the standard, which we assume is always part of our decision-making process. This may be something that should be considered, but I would want to have the assurance that we didn't overstep. That's all.

15:09:32

Now, how you do this, I'd have to ask Mike what he'd suggest.

MR. CONSTANTINO: Well, the annual reports, we get them but they won't --

15:09:38

CHAIRPERSON OLSON: That shows average length of stay.

MR. CONSTANTINO: Right.

MEMBER BURDEN: Would that give all the information that we want to have? Because this is a little different going on here, so I'd be more comfortable with approval.

15:09:46

CHAIRPERSON OLSON: So that would show us the age of the patients, the average length of stay. Does it cover the hours of rehab?

15:09:59

MR. CONSTANTINO: No.

CHAIRPERSON OLSON: I totally agree with you because I think we're trying to put a square peg in a round hole. I've been in favor of this model and have been outspoken. So I guess we can closely examine

that report.

MEMBER BURDEN: Would you be willing to return even though you don't have the facility functioning in a year or so or year and a half and
15:10:25 reporting, "Here's where we are and what we've still got?"

It's a simple enough thing to say as far as I'm concerned. I don't know how others feel about this other than Madam Chair. I feel this is something if
15:10:40 we're going to give you the okay to proceed I'd want to have a tag or something saying the reason for us to say okay has been sort of followed up really carefully.

MR. GREEN: I think policies and procedures -- there's a lot of things that you can do
15:10:58 while the construction guys are digging holes. They can certainly start building all of their clinical protocols and clinical policies and procedure and give you exactly what they're been talking about so you can actually see what it looks like and feels like.

15:11:12 CHAIRPERSON OLSON: So I would like to -- do we have a second -- first and second on the motion?

MR. ROATE: We have -- motion was made by Dr. Burden. No second.

CHAIRPERSON OLSON: Can I amend your motion to include that the applicant will appear back before the Board in one year if the project is approved to further educate us on how your facility will be
15:11:30 different than a traditional skilled nursing facility? Would that work for you? And policies and procedures might be a great way, pathways.

DR. ROUMELIOTIS: I'm okay with that.

CHAIRPERSON OLSON: So we have a motion.
15:11:44 Do I have a second with the motion as amended?

MEMBER DEMUZIO: Second.

MR. URSO: They agreed to this condition; right?

DR. ROUMELIOTIS: Yes.

15:11:57 MEMBER BURDEN: George, you need a typewriter. Read it back to us, please.

MR. ROATE: The condition is the applicant -- or the permit holder, if passed, will appear before the Board in one year with policies and
15:12:39 procedures in place to show the nursing service -- to explain how the nursing service is unique in its own specific mission.

CHAIRPERSON OLSON: Oh, that was even better than I said it.

Okay. We have a motion and a second.

MR. ROATE: I have a motion. I don't have a second.

CHAIRPERSON OLSON: The Senator seconded.

15:12:59 MR. ROATE: Okay. Motion made by Dr. Burden, seconded by Senator Demuzio.

Mr. Bradley.

MEMBER BRADLEY: The Board report continues to show that this project does not meet

15:13:13 planning area need, service accessibility, unnecessary duplication of service, or reasonableness of project costs as we look at the criteria, and for that reason I vote no.

MR. ROATE: Dr. Burden.

15:13:31 MEMBER BURDEN: I vote yes based on the prior conversations at that I've had.

MR. ROATE: Thank you, Doctor.

Senator Demuzio.

MEMBER DEMUZIO: Yes, based upon the

15:13:41 prior consideration and the question that was raised before.

MR. ROATE: Thank you, ma'am.

Mr. Hayes.

MEMBER HAYES: I'm going to vote no

based on the information that -- from the State Agency report.

I do think we need more concrete information on this project. You know, the idea of approving it and then getting yearly reports is something that we haven't done at the Board here, and I feel that we have to -- we have to be able to approve a project as is and then be able to -- you know, to live with it, I suppose.

15:14:16

You know, I find very little information about how this -- about the other facilities that may be able to help us or other facilities that are operating here or, as David just said, that this is kind of like taking the -- I would imagine it's taking ultimately the cream of the crop reimbursement, and I'm agreeing that that might be right to do or this facility could do that and have good outcomes. But taking it away from traditional nursing homes might take their financial viability into question, and I think we've seen that in the past from the opposing letters. So I'm going to vote no.

15:14:45

15:15:15

15:15:42

MR. ROATE: Thank you, sir.

Madam chair.

CHAIRPERSON OLSON: I vote yes based on the fact that I continue to believe this represents a

different model and offers access to care for a patient population and a patient demographic that is not receiving the care they should get.

MR. ROATE: Thank you, Madam Chair.

15:15:58 That's three votes in the positive, two in the negative.

CHAIRPERSON OLSON: The motion fails. Thank you.

MR. URSO: You're going to be receiving

15:16:08 a denial with an opportunity to request an administrative hearing if you so desire.

CHAIRPERSON OLSON: Mr. Bradley.

MEMBER BRADLEY: I agree that this does not seem to fit our current criteria, and I also think

15:16:24 it's an innovative approach that we ought to be able to consider. How do we change our rules or criteria to take this into account?

CHAIRPERSON OLSON: I think it's something we should perhaps ask the long-term care

15:16:37 committee take a look at and see if we need to create a new category of service. We're bound by the confines of our particular rules, so maybe that's something you guys could advocate for with the long-term care committee, and I guess it would be a legislative change

to add a category of service than what already exists. And that -- perhaps the Department of Public Health, as well.

Thank you.

15:17:10 Other Business, there's none.

Rules Development, Claire has something for us, I think.

MS. BURMAN: Okay. We are going to be revisiting language that the Board reviewed at the last

15:17:46 meeting in February. It's the new subsection that was proposed to be added to the ASTC rule making. It's the transition period for meeting --

MS. AVERY: I'm sorry.

(Discussion off the record.)

15:18:18 MS. BURMAN: A question was raised when the Board was considering this language, and the question was regarding those ASTCs that received a permit with a condition and how this new subsection would impact them.

15:18:32 So we spoke with JCAR about that question, and they proposed the new language. This was sent to you via e-mail, and hopefully you had a chance to look at it.

Essentially it exempts those ASTCs that have

conditional permits from the requirements of this new subsection.

CHAIRPERSON OLSON: Do you need a motion to accept that in the language?

15:19:12 MR. ROATE: Dr. Burden.

CHAIRPERSON OLSON: We have one more motion to make. Can you stand there and vote?

MEMBER BURDEN: Sure.

CHAIRPERSON OLSON: May I have a motion

15:19:22 to accept the language as amended and approved by JCAR that Claire just read to us? Do we have a motion?

MEMBER HAYES: Motion.

CHAIRPERSON OLSON: Thank you. Second?

MEMBER BURDEN: Second.

15:19:37 MR. ROATE: Motion made by Mr. Hayes, seconded by Dr. Burden.

Mr. Bradley.

MEMBER BRADLEY: Yes.

MR. ROATE: Dr. Burden.

15:19:45 MEMBER BURDEN: Yes.

MR. ROATE: Senator Demuzio.

MEMBER DEMUZIO: Yes.

MR. ROATE: Mr. Hayes.

MEMBER HAYES: Yes.

MR. ROATE: Madam Chair Olson.
CHAIRPERSON OLSON: Yes.
MR. ROATE: Five votes in the affirmative.
MR. CONSTANTINO: Madam Chairwoman, we
15:19:56 do need a motion to remove Edison Hospital from the inventory.
CHAIRPERSON OLSON: That takes a motion?
MR. ROATE: Do you want to just put it on the April agenda?
15:20:10 MR. CONSTANTINO: Yes.
CHAIRPERSON OLSON: Everybody received the financial report. Are there any questions on that report?
(No response.)
15:20:17 CHAIRPERSON OLSON: There being none, I'll move onto the Legislative Update.
MS. AVERY: As you know, our legislative initiative was House Bill 5958 that's sponsored by Representative Will Davis. It has moved out of the
15:20:30 rules committee and will be heard by the human services committee on March the 20th at 8:30.
Senator Sandoval's bill that has to do with the capital expenditure report, Senate Bill 2628, is still kind of in limbo. It's currently postponed in

the State Government of Veterans Affairs committee as of today when I checked earlier. And I haven't been able to get any clear direction on where they're trying to go or if they're seeking any other amendments to the
15:21:02 language with other entities like the Hospital Association, but right now we're still neutral on that bill.

CHAIRPERSON OLSON: Questions regarding the legislative update?

15:21:14 (No response.)

CHAIRPERSON OLSON: Frank, Annual Ethics Training and Statements of Economic Interest.

MR. URSO: Cathy just handed out the annual ethics training package, and I would ask that
15:21:30 you please review that and sign the last page after you review it and get that back to Cathy or myself. The deadline is April 22nd, which just happens to be the next Board meeting. So if you want to get it to us sooner, that's not a problem. That's the annual ethics
15:21:49 training.

The next one is the statement of economic interest. That's the cover letter you also have in your package. The statement of economic interest is going to be mailed out around May 17th from the

Secretary of State. You need to complete that document and give the original, please, back to Cathy or myself. Once again, that deadline is April 22nd. If you want to mail it back, Cathy gave out some envelopes or if
15:22:22 you need an envelope to mail it back. So those are two documents that need to be reviewed and action needs to be taken.

Are there any questions? There's a cover letter for the statement of economic interest.

15:22:36 CHAIRPERSON OLSON: Economic interest is going to come in the mail?

MR. URSO: You should have a cover letter there explaining it. There's a cover letter that's explaining it, and then the full package is
15:22:48 there for the ethics training.

CHAIRPERSON OLSON: I'm sorry. I've got it. Thank you.

MR. URSO: Thank you.

CHAIRPERSON OLSON: Questions regarding
15:22:54 those two?

(No response.)

CHAIRPERSON OLSON: Okay. The next meeting is April 22nd, which is a Thursday, in Chicago at the Holiday Inn Merchandise Mart, and the meeting

will begin at 9:00 a.m.

I will entertain a motion to adjourn.

MEMBER HAYES: So moved.

CHAIRPERSON OLSON: Second. Can I

15:23:18 second it? Wait a minute, we don't have a quorum. We'll recess until April.

MR. CARVALHO: Under rules of order they say that the chair is an allowed to declare a meeting adjourned if the agenda has been exhausted.

15:23:45 CHAIRPERSON OLSON: Meeting adjourned. Agenda exhausted and so are the board members.

PROCEEDINGS CONCLUDED AT 3:24 P.M.

STATE OF ILLINOIS)
) SS.
COUNTY OF K A N E)

I, Paula M. Quetsch, Certified Shorthand Reporter No. 084-004299, CSR, RPR, and a Notary Public in and for the County of Kane, State of Illinois, do hereby certify that I reported in shorthand the proceedings had in the above-entitled matter and that the foregoing is a true, correct, and complete transcript of my shorthand notes so taken as aforesaid.

IN TESTIMONY WHEREOF I have hereunto set my hand and affixed my Notarial Seal this 25th day of March, 2014.

Certified Shorthand Reporter
Registered Professional Reporter

My commission expires
October 16, 2017