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## Transcript of **Full Meeting**

**Date:** May 10, 2016

**Case:** State of Illinois Health Facilities and Services Review Board

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ILLINOIS DEPARTMENT OF PUBLIC HEALTH  
HEALTH FACILITIES AND SERVICES REVIEW BOARD  
OPEN SESSION - MEETING

REPORT OF PROCEEDINGS  
Normal, Illinois 61761  
Tuesday, May 10, 2016  
10:05 a.m.

BOARD MEMBERS PRESENT:

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

Job No. 93891

Pages: 1 - 242

Reported by: Lisa Hahn Peterman, CSR, RMR

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EX OFFICIO MEMBERS PRESENT:

BILL DART, IDPH

ARVIND K. GOYAL, IHFS

ALSO PRESENT:

JUAN MORADO, JR., General Counsel

JEANNIE MITCHELL, Assistant General Counsel

COURTNEY AVERY, Administrator

NELSON AGBODO, Health Systems Data Manager

MICHAEL CONSTANTINO, IDPH Staff

BONNIE HILLS, IDPH Staff

GEORGE ROATE, IDPH Staff

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P R O C E E D I N G S

CHAIRWOMAN OLSON: The meeting will come to  
order.

George, will you call the roll, please?

MR. ROATE: Thank you, Madam Chair.

Mr. Sewell.

MEMBER SEWELL: Present.

MR. ROATE: Mr. McGlasson.

MEMBER MCGLASSON: Yes, sir.

MR. ROATE: Mr. Johnson.

MEMBER JOHNSON: Present.

MR. ROATE: Thank you, sir.

Justice Greiman.

MEMBER GREIMAN: Present.

MR. ROATE: Mr. Galassie.

MEMBER GALASSIE: Present.

MR. ROATE: Senator Demuzio.

MEMBER DEMUZIO: Present.

MR. ROATE: Senator Burzynski.

MEMBER BURZYNSKI: Here.

MR. ROATE: Mr. Hayes.

VICE CHAIRMAN HAYES: Here.

MR. ROATE: Madam Chair.

CHAIRWOMAN OLSON: Present.

1 MR. ROATE: There are nine members in  
2 attendance.

3 CHAIRWOMAN OLSON: That's wonderful.

4 The first order of business is executive  
5 session. We'll be in executive session for approximately  
6 how long?

7 MS. MITCHELL: Twenty minutes.

8 CHAIRWOMAN OLSON: About 20 minutes, so I need  
9 everybody to clear the room so we can go into executive  
10 session, please. Thank you.

11 May I have a motion to go into closed session  
12 pursuant to Sections 2(c)(1), 2(c)(5), 2(c)(11), and  
13 2(c)(21) of the Open Meetings Act?

14 VICE CHAIRMAN HAYES: So move.

15 CHAIRWOMAN OLSON: All in favor say aye.

16 (Ayes heard.)

17 CHAIRWOMAN OLSON: Motion passes.

18 (At 10:08 a.m. the Board adjourned into  
19 executive session. Open session  
20 proceedings resumed at 10:37 a.m. as  
21 follows:)

22 CHAIRWOMAN OLSON: We're now back in session.  
23 I'm told you cannot hear me in the back. I'll try to be  
24 louder. Can you hear me now?

1 MEMBERS OF THE PUBLIC: Yes.

2 CHAIRWOMAN OLSON: If you can't hear me, wave  
3 your hand and I'll speak up. Nobody ever has trouble  
4 hearing me.

5 Okay. The next order of business is compliance  
6 issues, settlement arrangements, and final orders.

7 Juan?

8 MR. MORADO: Yes. Thank you.

9 We're going to be seeking a final order on  
10 St. Paul's Home, Case Number HFSRB #15-010, also known as  
11 Project #13-003.

12 CHAIRWOMAN OLSON: May I have motion to approve  
13 the final order for St. Paul's Home?

14 MEMBER GALASSIE: So move.

15 CHAIRWOMAN OLSON: Is there a second?

16 MEMBER SEWELL: Second.

17 CHAIRWOMAN OLSON: Roll call vote, please?

18 All those in favor, say aye.

19 (Ayes heard.)

20 Opposed?

21 (No response.)

22 The motion passes. The final order is  
23 approved.

24 There were no referrals to legal counsel.

1                   The next order of business is approval of the  
2 agenda.

3                   May I have a motion to approve the May 10,  
4 2016, Agenda?

5                   MEMBER DEMUZIO: So move.

6                   CHAIRWOMAN OLSON: And a second, please?

7                   VICE CHAIRMAN HAYES: Second.

8                   CHAIRWOMAN OLSON: All in favor, say aye.

9                   (Ayes heard.)

10                  The motion passes.

11                  May I have a motion to approve the March 29,  
12 2016, meeting transcripts?

13                  VICE CHAIRMAN HAYES: No move.

14                  MEMBER GALASSIE: Second.

15                  CHAIRWOMAN OLSON: All those in favor, say aye.

16                  (Ayes heard.)

17                  The motion passes.

18                  The next order of business is public  
19 participation.

20                  I believe we have quite a lengthy public  
21 participation. I will remind you, each person speaking  
22 gets two minutes. That's exactly two minutes -- not two  
23 minutes and one second -- two minutes. Nelson will tell  
24 me in his best outside voice when two minutes are up and

1 I will ask you to conclude your comments.

2 May we have the first five, Jeannie?

3 MS. MITCHELL: Yes.

4 When you're called, please come up to the table  
5 right there, and please state and spell your name for the  
6 benefit of the court reporter.

7 You do not have to speak in the order in which  
8 you are called, and please do not forget to sign in.

9 The first five for Project 15-056, Transitional  
10 Care of Lisle: Renée Garvin, Patti Long, Larry Banks,  
11 Fred Berkovits, and Elliot Triplett.

12 CHAIRWOMAN OLSON: Are the two other people  
13 that were here in the room that were called? They are  
14 not. Okay.

15 Do you want to call two more, or do you want to  
16 move on to a different project?

17 MS. MITCHELL: All right. I will also call  
18 John Vrba and Daniel Weiss.

19 CHAIRWOMAN OLSON: We're still missing one. Is  
20 this person in the room? No?

21 Okay. Do you want the try one more?

22 MS. MITCHELL: Gloria Pindlak.

23 CHAIRWOMAN OLSON: No.

24 MS. MITCHELL: Julia Buchler.

1 MR. CONSTANTINO: There's a microphone in front  
2 of you and you need to turn it on.

3 CHAIRWOMAN OLSON: Would you all please be  
4 sworn in by the court reporter? Oh, I'm sorry. You  
5 don't need to do that. We're in public participation.  
6 Forgive me.

7 Okay. Please begin. No order is necessary.  
8 Just grab a mic and start.

9 MS. BUCHLER: Hello. My name is Julia Buchler,  
10 B-U-C-H-L-E-R, from Chicago, Illinois. I am a licensed  
11 speech language pathologist that has been working in the  
12 skilled nursing setting for eight years.

13 I have been Director of Therapy for seven  
14 years, overseeing physical, occupational and speech  
15 therapists. I am a member of the American Speech,  
16 Language and Hearing Association and the National  
17 Association for Rehab Agencies and Providers.

18 As a rehab director, it is imperative to stay  
19 abreast of current therapy legislation, compliance  
20 standards, and CMS regulations to maintain a grasp on the  
21 ever-changing needs of the health care world.

22 With the fee-for-service model beginning to  
23 fade away and bundle payments/risk sharing models  
24 surfacing, there are simply not rehab centers to

1 accommodate a comprehensive short-stay rehab program.

2 The need for short-stay rehab buildings  
3 focusing on providing the most efficient, comprehensive,  
4 and functional treatment plan is becoming a growing need  
5 in Illinois.

6 Therefore, I am here in support of Transitional  
7 Care of Lisle and Transitional Care of Arlington Heights.

8 The ability to provide a cohesive  
9 clinical/rehab model, intensely focusing on returning  
10 guests to their prior living accommodations is something  
11 that the Transitional Care Centers will provide to the  
12 community.

13 Thank you.

14 CHAIRWOMAN OLSON: Thank you.

15 MS. GARVIN: Renée Garvin, G-A-R-V-I-N.

16 I am here as the Executive Director for Monarch  
17 Landing, which is a senior living community comprised of  
18 independent living, assisted living, long-term care, and  
19 short-term rehabilitation care, located within planning  
20 area 7-C, the same as the Applicant, Transitional Care of  
21 Lisle. I am here today in opposition of this project.

22 The Springs at Monarch Landing Health Center is  
23 a five-star rated, 96 bed, skilled nursing facility. Our  
24 community opened in November 2014 to serve the post-acute

1 care and long-term care needs for residents living at  
2 Monarch Landing and in the greater Naperville area. Our  
3 building was designed to have six separate living areas,  
4 featuring predominately private rooms with en-suite  
5 baths. This unique design is smaller in scale, catering  
6 to just 16 individuals each.

7 Currently, two of these areas are dedicated to  
8 providing personalized post-acute care to individuals  
9 discharging from the hospital.

10 From a programmatic perspective, Monarch  
11 Landing has partnered with Edward Medical Group, an  
12 affiliate of Edward Hospital, to provide a full-time  
13 physician. We are the first and only community in our  
14 geographic area to have a dedicated full-time primary  
15 care physician, which enables our patients to receive the  
16 timeliest and most advanced medical care in skilled  
17 nursing today.

18 Transitional Care of Lisle claims their project  
19 is filling a service not currently available within the  
20 geographic area. This is simply not true. The Springs  
21 at Monarch Landing is designed both physically and  
22 programmatically to care for adults of varying ages with  
23 post-acute care needs.

24 During the planning phases for The Springs at

1 Monarch Landing, demand for short-term rehab services was  
2 calculated to be upwards of 60 individuals per day.  
3 However, with the onset of accountable care and the  
4 continued decrease in average length of stay of a  
5 patient, we are beginning to question whether there will  
6 be enough demand to fill the beds we've built less than  
7 two years ago.

8 If the CON is granted to Transitional Care of  
9 Lisle, we anticipate that our occupancy will be  
10 negatively impacted, which will cause serious financial  
11 implications to our organization and those we serve. We  
12 ask that you deny this project.

13 CHAIRWOMAN OLSON: Would you -- if you have  
14 your comments typed, would you please give them to the  
15 court reporter?

16 Next, please.

17 MR. BERKOVITS: Fred Berkovits,  
18 B-E-R-K-O-V-I-T-S.

19 Good morning. I'm the Regional Director of  
20 Operations for Bria Health Services and I'm here on  
21 behalf of Bria of Westmont. I'm here to oppose the  
22 project.

23 Our facility serves both the long-term medical  
24 population and the short-term rehab population. Our

1 census at Westmont, a 215-bed skilled facility, is at 69  
2 percent. In Westmont, we just completed a six million  
3 dollar addition and renovation. We did not add a single  
4 bed, and the money we spent did not exceed the Board's  
5 threshold for a CON. If we wanted to add beds, using the  
6 ten percent rule, we could have added 20 beds. Any claim  
7 that more beds are needed is simply not true. The reason  
8 we didn't add beds is because there's no need for  
9 additional beds.

10 In essence, we provide the exact same services  
11 as those proposed. Bria Services serves the same  
12 population that this Applicant is claiming to serve, and  
13 we were able to do this without the need for a CON or by  
14 creating additional duplicative services in the market.  
15 In fact, 62 facilities in the same geographic area are  
16 providing all of the proposed services. Of those 62  
17 facilities, 49 of them, or 80 percent, are not in the  
18 state target of 90 percent occupancy.

19 Given that there's so many facilities under the  
20 utilization threshold, good facilities, it's hard to  
21 imagine needing another two facilities that will only  
22 serve one small portion of the skilled nursing community.

23 In conclusion, it's impossible for the proposed  
24 facilities to succeed without taking away an entire

1 subset of patients from the existing facilities, a subset  
2 of patients that represent most over-served patient  
3 population at the expense of the long-term skilled  
4 patient, which represents the most underserved  
5 population.

6 We all have the ability and the capacity to  
7 serve this resident population, and there's no need for  
8 this Board to approve this project.

9 Thank you.

10 CHAIRWOMAN OLSON: Thank you.

11 Next, please?

12 MR. BANKS: Hello. My name is Larry Banks.  
13 I'm the Administrator of Community Nursing and Rehab  
14 Center. We are located a few minutes from the proposed  
15 site of Project 15-056, which, if approved, would have a  
16 devastating effect on our facility and other providers in  
17 the planning area.

18 On page 60 of the application, the Applicant  
19 states the project is necessary, and I quote, for  
20 improving access to a particular type of patient  
21 requiring transitional care following a hospital stay.  
22 This service is not currently offered in the planning  
23 area, end quote.

24 On page 64, another quote: No existing skilled

1 nursing facility in the area provides the level of care  
2 proposed by this Applicant, end quote.

3 These are both false claims and show a total  
4 lack of understanding as to what services the area  
5 facilities provide.

6 Community is a Joint Commission accredited and  
7 preferred provider in the Illinois Health Partner ACO,  
8 working closely with the area hospitals to provide the  
9 post-acute, short-term transitional care following the  
10 hospital stay at the lowest possible cost. We specialize  
11 in all of the services listed by the Applicant.

12 In addition to our medical staff, we include  
13 pulmonary, cardiac, infectious disease, nephrology, and  
14 wound care specialists, who run weekly in our facility,  
15 as well as on-staff seven-day-a-week nurse practitioner  
16 services.

17 Over the past 12 months, there's been a  
18 substantial decrease in the length of stay of the  
19 patients receiving post-acute care at our facility and  
20 the other facilities in the area. This is due to the  
21 focus on the ACOs and all providers for sending patients  
22 home earlier and pushing for shorter length of stay.

23 I would like to point out that nowhere in the  
24 application or in the subsequently submitted documents

1 does the Applicant mention the fact that a new facility  
2 with all the amenities the Applicant provides -- is  
3 proposing to provide was just built and recently opened  
4 minutes from this proposed facility. There is no reason  
5 to add any new facilities, let alone two, before this  
6 recently-opened facility is at the utilization standard  
7 and this has not happened.

8 CHAIRWOMAN OLSON: Thank you.

9 MR. VRBA: Good morning. My name is John Vrba,  
10 V-R, B as in boy, A.

11 I'm the owner and operator of Burgess Care  
12 Nursing Rehabilitation Center and also the current  
13 President of the Illinois Health Care Association.

14 I oppose Project 15-506 -- 056, Transitional  
15 Care of Lisle, because I've been involved in skilled  
16 nursing facilities in DuPage County, the  
17 Hinsdale/Westmont area, for over 25 years, and there has  
18 never -- underscore never -- been the need for a project  
19 like this.

20 You've heard from several facilities about how  
21 we all provide the care that Transitional Care says is  
22 not available. We are not afraid of competition, but  
23 when someone comes in and proposes to skim off high  
24 reimbursement residents from other area facilities to put

1 their interests ahead of the community, we are going to  
2 speak up, which is what we're doing today.

3 However, I want to raise a specific point about  
4 the Lisle project that I hope this Board will look into.

5 When this project was filed, they asked for  
6 "expedited review" because if their CON was not approved  
7 before April 21st, they would lose the right to buy the  
8 land for this facility, and it would result in  
9 significant and costly delays. They did not get  
10 "expedited review." Instead, they got delayed because of  
11 how much information was missing from their application.

12 In the extra 400 pages of materials, they  
13 provided a copy of the contract to buy the land, and sure  
14 enough, they were telling the truth.

15 As this project is being heard today on May 10,  
16 2016, according to the terms of the contract they entered  
17 into, Transitional Care has no rights to buy the land  
18 they plan to put the facility on.

19 Transitional Care projects have had issues  
20 before. In Arlington Heights, they altered their project  
21 by changing funding without permission. In Naperville,  
22 they had to abandon the project because they could not  
23 get the zoning approved. Here, they tried to avoid  
24 identifying the company owning 90 percent of the project

1 as a co-Applicant, and now they want you to approve Lisle  
2 when they have no right to buy the land.

3 I'm sure they will claim there is no problem,  
4 that they took care of it, but if that is so, why didn't  
5 they submit any documentation to the Board? That issue  
6 keeps popping up throughout the project, claims made with  
7 absolutely no documentation. They keep asking everyone  
8 to take their word for it.

9 On top of that, what about all the significant  
10 and costly delays? How could the Board approve this  
11 project without that information?

12 There are lots of reasons not to approve this  
13 project, but the fact that they can't even prove they  
14 have a right to buy the land is reason enough to deny  
15 this project.

16 Thank you.

17 CHAIRWOMAN OLSON: Thank you. Thank you all.

18 Next five, please?

19 MS. MITCHELL: The next five are Heidi  
20 Reich-Aguilar, Brianne Zitko, Servilla S. Quinn, Dana M.  
21 Trawczynski and Randy Fike.

22 CHAIRWOMAN OLSON: These are all the same  
23 project for the Board's information.

24 You can start.

1 MS. ZITKO: Good morning.

2 My name is Brianne Zitko, and I'm speaking  
3 today in favor of Transitional Care of Lisle.

4 I have been a resident of Naperville/Lisle area  
5 for 25 years and I have been working in health care for  
6 15 years. Over the last several months, the home health  
7 organization that I work for has been working with the  
8 Transitional Care of Arlington Heights team. They have  
9 been providing post-acute care to many of our patients.  
10 Transitional Care of Arlington Heights has provided high  
11 quality care to our patients, and our patients and their  
12 families have been highly satisfied with their service  
13 there. Seniors are starting to expect a higher level of  
14 customer service in a more homelike environment as they  
15 seek out post-acute care facilities.

16 Health care has been lacking customer service  
17 and hospitality in a subacute world and Transitional Care  
18 of Arlington Heights has found a way to infuse a  
19 pleasant, homelike customer experience into a strong  
20 clinical skilled nursing care model.

21 Transitional Care has reinvented the subacute  
22 model, as they deliver quality health care outcomes in a  
23 modern, homelike environment for their guests. Their  
24 therapy team is educated on innovative therapy

1 techniques, and they offer each patient an individualized  
2 care plan to help them recover. They have hired some of  
3 the best nurses in the industry, and their proactive  
4 management of their patient's clinical needs makes them  
5 one of the best post-acute facilities in the Chicago  
6 area.

7 But aside from that work experience with  
8 Transitional Care of Arlington Heights, my primary goal  
9 is to speak from a consumer view to advocate for the need  
10 for a facility like Transitional Care in the  
11 Naperville/Lisle area.

12 My uncle almost lost his life in a traumatic  
13 car accident recently. He was rushed to Lutheran General  
14 for several trauma surgeries after the accident. He was  
15 hospitalized for 45 days and he needed to transfer to a  
16 post-acute facility in the Naperville area. He was 55  
17 years old at the time, and at all the facilities we  
18 looked into, none of them suited his needs. He could not  
19 go home because of his fragile state, but every  
20 post-acute facility that we visited was designed for  
21 seniors who were in their 80s. He ended up going to a  
22 rehab facility for several months and the environment was  
23 less than ideal for him. This led to a long, difficult  
24 road to recovery for him.

1 MR. AGBODO: Two minutes.

2 MS. ZITKO: So Transitional Care of Arlington  
3 Heights would be a tremendous asset to the Naperville  
4 area.

5 CHAIRWOMAN OLSON: Thank you.

6 MS. REICH-AGUILAR: Hi. My name is Heidi  
7 Reich-Aguilar and I'm from LaGrange, Illinois.

8 I'm speaking today in favor of Transitional  
9 Care of Lisle. Over the last several months, I've had  
10 the pleasure of working with Transitional Care of  
11 Arlington Heights team as a post-acute care provider.  
12 Having been in the post-acute care field for many years,  
13 witnessing various levels of service, I can confidently  
14 say Transitional Care offers a place of healing that is  
15 second to none. The therapy team is well versed on  
16 cutting edge techniques and modalities that offer an  
17 expedited healing rate to those that have chosen  
18 Transitional Care to recover. This, paired with  
19 exceptional nursing, care coordination, communication  
20 between disciplines, and support offered to their guests,  
21 places Transitional Care of Arlington Heights in an elite  
22 class of subacute care providers.

23 This is especially important to those who  
24 reside in assisted living or an independent living

1 facility. Being away from home is both mentally and  
2 financially taxing, as the patient is responsible for the  
3 costs associated with the community while they are away.  
4 We often see patients preoccupied with cost of living  
5 when their focus should be on healing. With Transitional  
6 Care promoting a quick recovery, this has decreased the  
7 burden of these patients by allowing them to return home  
8 with post-acute care providers to manage the next stage  
9 of healing.

10 Transitional Care of Lisle will be an asset to  
11 the community, as we, the post-acute care provider, have  
12 received many compliments on the care rendered at  
13 Transitional Care of Arlington Heights.

14 The accommodations, privacy, support, and  
15 rehabilitation programming is a model of success. The  
16 patients discharged to our care over the last several  
17 months have been successful in their transition back to  
18 the place they love most, their home. This model of care  
19 should be available to all those in need.

20 I leave you today with my strong feelings of  
21 support for Transitional Care of Lisle. My parents are  
22 baby boomers residing in Naperville, and they are in  
23 strong support of transitional care management and look  
24 forward to having a choice to recover there.

1 Thank you for the time and opportunity.

2 CHAIRWOMAN OLSON: Thank you.

3 Next.

4 MS. TRAWCZYNSKI: My name is Dana Trawczynski,  
5 T-R-A-W-C-Z-Y-N-S-K-I.

6 I am a registered nurse with a focus in  
7 cardiology and a resident of Arlington Heights. As a  
8 nurse, I worked at a hospital where our goal is to  
9 quickly stabilize and discharge patients. I have chosen  
10 to work at Transitional Care because I want to connect  
11 more with my guests and help make a real difference in  
12 their lives going forward, so they can stay out of the  
13 hospital in the future.

14 I think that making this connection, educating  
15 guests, is particularly important in cardiac care. Heart  
16 failure is among the top disease states for hospital  
17 admission and mortality. You can't change the genetics  
18 of heart disease, but you can certainly fight the disease  
19 with prevention, personalized care planning, and  
20 educating on healthy behaviors during a rehab stay.

21 At Transitional Care, our focus is on wellness.  
22 We don't just send our guests home with a list of  
23 medications and generic discharge instructions. We treat  
24 the whole person by providing personalized education to

1 both the guest and their families. Throughout their  
2 stay, we help prepare them to make better lifestyle  
3 choices.

4 We teach about healthy food options and offer  
5 cooking demonstrations; we stress the importance of  
6 self-monitoring and follow-up care, and we teach our  
7 guests how to track their symptoms and recognize warning  
8 signs before they have to be readmitted to the emergency  
9 room.

10 In short, we begin planning for the day they'll  
11 be discharged the moment they step into our center.

12 Recently, I cared for a guest who was admitted  
13 with a complex case that required multiple medical  
14 interventions. His goal was not only to improve his  
15 cardiac health, but regain his strength and stamina to  
16 see his son compete in a sports competition that was  
17 statewide. Nursing tailored his care plan to meet his  
18 needs and brought in family members to participate in  
19 therapy and educational sessions. With this approach, we  
20 made his rehab stay much more meaningful to him. I'm  
21 happy to say, he was safely able to leave and see his son  
22 compete, and when he returned, the hug he gave me  
23 affirmed transitional care is a critical piece of the  
24 healthcare puzzle.

1 I encourage you all to embrace this concept of  
2 health care and allow transitional care to continue to  
3 grow and expand.

4 Thank you.

5 CHAIRWOMAN OLSON: Thank you.

6 Good morning. I am here to ask you to support  
7 Transitional Care of Lisle.

8 My name is Servilla Quinn, Q-U-I-N-N, and I'm  
9 from Arlington Heights, Illinois. I am a certified  
10 nursing assistant.

11 I would like to say that Transitional Care  
12 Centers are different than those buildings that say they  
13 do transitional care.

14 Some of the highlights are: Daily showers are  
15 available; restaurant dining with food and socialization  
16 that patients rave about; therapy seven days a week;  
17 better ratio of clinical team members to patients; use of  
18 iDevices for documentation and patient tracking; a  
19 culture of courtesy for each other and patients.

20 Patients that are younger and sicker are  
21 looking for the clinical and therapy services and  
22 enjoying the amenities to achieve their goals and return  
23 home.

24 Thank you for your support of this project.

1 CHAIRWOMAN OLSON: Thank you.

2 Next?

3 MR. FIKE: Good morning. My name is Randy  
4 Fike, F-I-K-E, and I'm the CEO of Post Acute Network  
5 Solutions. We provide care coordination for select Blue  
6 Cross Blue Shield of Illinois Medicaid members.

7 Previously, I was the president of one of the  
8 largest Medicare advantage health care companies in  
9 Illinois, called HealthSpring. We managed approximately  
10 20,000 lives.

11 As such, I understand managing health care risk  
12 and I value health care partners, like the proposed  
13 Transitional Care Lisle and Transitional care of Aurora,  
14 who "get it." We're all looking for lower costs and  
15 better outcomes.

16 I have been -- I have worked in health care for  
17 over 30 years, and like many of you, I've witnessed  
18 dramatic changes in the industry. I believe the  
19 traditional skilled nursing model no longer meets the  
20 rehab needs of the new risk-taking entities.

21 Highly specialized, purpose-built, dedicated  
22 short-term rehab centers like the proposed Transitional  
23 Care centers offer: The right training, the right  
24 equipment and amenities, and the right processes and are

1 a better, more appropriate fit with the new health care  
2 model.

3 It's time that we rethink how we do healthcare.  
4 We need providers like transitional care centers if  
5 Illinois Medicare -- Medicaid is going to be successful  
6 in controlling costs and increasing quality.

7 As a Joint Statement -- as a recent Joint  
8 Statement of the FTC and the Antitrust Division of the  
9 United States Department of Justice reports, CON laws  
10 should not be abused to remove, reduce or delay the  
11 competitive pressures that typically incentivize  
12 incumbent firms to innovate, improve existing services,  
13 introduce new ones, or moderate prices. I agree. Now is  
14 the time for innovation.

15 Thank you for your time this morning.

16 CHAIRWOMAN OLSON: Thank you all.

17 The next five, Jeannie?

18 MS. MITCHELL: The next five are Alan  
19 Itzkowitz, Tom Nelson, Randy S. Hertel, Brad Danegger  
20 and Mark Goode. Please remember to spell your names --  
21 state and spell your name when you begin speaking for the  
22 benefit of the court reporter, and don't forget to sign  
23 in.

24 CHAIRWOMAN OLSON: Go ahead. Somebody can

1 start, please.

2 MR. DANNEGGER: Hello. My name is Brad  
3 Dannegger, D-A-N-N-E-G-G-E-R, and I'm a resident of  
4 Wheaton, Illinois, which is within the service area for  
5 the proposed Transitional Care of Lisle.

6 As a local resident, I'm intrigued by the  
7 opportunity that transitional care could offer my family,  
8 should we ever need it, and as a business owner and  
9 president of a company, I appreciate the quality,  
10 efficiency and cost-effectiveness that transitional care  
11 promises to deliver as well.

12 Currently, the only local option for  
13 in-patient, post-hospital care, in the area that I'm  
14 aware of is a traditional nursing home, which, in my  
15 mind, is more institutional in nature and primarily  
16 serves long-term residents. It does not seem to be an  
17 ideal setting for many short-term patients who need  
18 rehab, especially younger patients.

19 My understanding is that as people are  
20 increasingly being discharged from the hospital setting  
21 sooner, transitional care centers are opening in other  
22 markets around the country. These centers specialize in  
23 getting people back on their feet quicker and at less  
24 cost.

1           Specializing in faster recovery speaks to me  
2 not only as a local resident, but as a business owner as  
3 well. If the quality of care remains on par or better  
4 (and I understand that the results show the quality is  
5 better with transitional care) and the costs and downtime  
6 are lower, that only helps me as a business owner who  
7 wants to take care of his employees and also wants to see  
8 them back to work as soon as possible.

9           Also, as a business owner, I believe in the  
10 free market economy. I think that a little healthy  
11 competition is good. It has a tendency to drive down  
12 pricing, increase quality and give rise to innovation.

13           Lastly, a new transitional care center in our  
14 community will generate taxes and jobs for our area,  
15 which is an added benefit as well.

16           For all of those reasons, I strongly support  
17 Transitional Care of Lisle.

18           CHAIRWOMAN OLSON: Thank you.

19           MR. HERTEL: Good morning. I'm Randy Hertel  
20 from Hawthorn Woods, Illinois, and I support Transitional  
21 Care of Arlington Heights and Lisle.

22           I took my knee replacement procedure as a  
23 serious project in wanting to find the best doctor and  
24 rehab center that could expedite my recovery, so I

1 interviewed five surgeons to get their opinions and  
2 procedures to determine if I was a candidate for a  
3 bilateral knee replacement. The outcome was two out of  
4 five highly recommended bilateral replacement, so I  
5 studied the success rates and received referrals from  
6 patients that I knew used the same doctor.

7 My next project was to find the absolute best  
8 rehab facility to expedite my recovery, plus I promised  
9 my wife and surgeon that I would use a rehab facility.

10 Again, I asked for referrals, and my doctor had  
11 mentioned that a new one was possibly going to be open in  
12 time that I might want to look at. So, again, I  
13 interviewed three centers looking for the best in low  
14 infection rate, physical and occupational therapy,  
15 comfort and security, professionalism and attitude of  
16 staff, meals and diet.

17 The outcome was very clear to me that  
18 Transitional Care of Arlington Heights was the place for  
19 me.

20 Transitional Care of Arlington Heights gave me  
21 the confidence of everything I was looking for, plus, I  
22 liked the fact that they target short-term rehab  
23 patients, and the majority of their rooms are private,  
24 which allows for excellent comfort for sleeping and less

1 chance for infection. The facility is beautiful.

2 I spent nine days at Transitional Care of  
3 Arlington Heights after two days in the hospital. From  
4 the moment I was rolled into the center, I felt welcomed  
5 and in excellent hands. There was no wasted time like I  
6 had envisioned. They all were well-trained professionals  
7 and knew exactly what to do.

8 I was in severe pain, but bearable, and wanted  
9 them to push me, and that is exactly what they did. I  
10 went from a walker to a cane in a matter of a few days.  
11 Both physical and occupational therapy were at the top of  
12 their game in moving me along at a pace I was comfortable  
13 with, and I think we impressed each other.

14 The overall treatment I received from the  
15 departments was at a level that would be hard to surpass,  
16 which includes the nurses and techs, physical therapy,  
17 events coordinator, administrative staff.

18 I give full credit for my recovery to both my  
19 surgeon and Transitional Care of Arlington Heights.  
20 After three weeks, I was back at the local Y exercising  
21 on a cardio bike, and after three months, I was back on  
22 the golf course.

23 CHAIRWOMAN OLSON: Please conclude.

24 MR. HERTEL: What a fantastic outcome. I feel

1 20 years younger.

2 Thank you.

3 CHAIRWOMAN OLSON: Thank you.

4 MR. NELSON: Good morning. My name is Tom  
5 Nelson, N-E-L-S-O-N. As Randy left, I came in.

6 I'm here in support of Transitional Care of  
7 Lisle, as well as Arlington Heights. I'm 61 years old  
8 and selected Transitional Care of Arlington Heights for  
9 rehabilitation of my bilateral knee replacement.

10 I spent seven days at Transitional Care of  
11 Arlington Heights following my surgery. As anyone who's  
12 had a joint replacement can tell you, especially two  
13 joint replacements, rehab and pain control is key.

14 I received over two hours of physical therapy  
15 per day. I had one session in the morning and one in the  
16 afternoon. The clinical team made sure that my pain  
17 medication was given prior to therapy sessions because  
18 they knew I wanted to push it. Due to the comprehensive  
19 rehab program, I was able to walk out of the building  
20 after seven days.

21 I received exceptional attention to my personal  
22 medical and rehab needs. Everyone at Transitional Care  
23 treated me as family. The special level of "personal"  
24 care aided me in my mental rehab and physical rehab and

1 they allowed me to feel like a special person.

2 I live close enough that I stop in at least  
3 once a month to check on all my friends at Transitional  
4 Care of Arlington Heights.

5 Thank you.

6 CHAIRWOMAN OLSON: Okay. Can we ask the two of  
7 you to race and see who does better?

8 (Laughter.)

9 MR. GOODE: Hello. My name is Mark Goode,  
10 G-O-O-D-E, and I'm here to support the Transitional Care  
11 of Lisle center project. I'd like to take a moment to  
12 give you a family member's perspective as it relates to  
13 our transitional care experience.

14 At age 63, my wife Caryn was fighting both lung  
15 and brain cancer. She was hospitalized, but she was too  
16 sick to manage the three hours of rehabilitation required  
17 to stay in the hospital. As such, we were asked to leave  
18 the hospital and we were provided a list of nursing homes  
19 to consider.

20 The thought of having her go to one of these  
21 nursing home facilities was devastating to both her and  
22 myself. We wanted and needed a facility that was focused  
23 on getting stronger and healthier to then move her to our  
24 home.

1           After visiting a few options, I learned about a  
2           new transitional care center that had recently opened in  
3           Arlington Heights. When I visited there, I felt that not  
4           only was the physical plant impressive, but the approach  
5           to rehab, the care offered, and the overall appeal and  
6           the concept of "wellness meets hospitality" culture that  
7           was there was even better. They even had accommodations  
8           for me to stay with my wife, which was not an option at  
9           the other places. This was very important to her and me  
10          because Caryn was very scared about her situation and  
11          wanted me to be with her.

12           Transitional Care was the obvious best choice  
13          for us. The only problem was that because they just  
14          opened, they could not accept Blue Cross and Blue Shield  
15          insurance. Regardless, we decided to move Caryn to the  
16          transitional care center and paid privately because the  
17          other options were not acceptable to her.

18           Caryn's therapy was adjusted to her needs and a  
19          focus on getting her home so that she could live  
20          comfortably with minimal family assistance.

21           I remain grateful for being able to offer her  
22          this option to continue her fight with dignity in a place  
23          where we both felt comfortable.

24           I'm not in the business of health care, like

1 many of you, but I can promise you that if at any time  
2 that you or a loved one should need care like this, this  
3 type of center is the place you'll want to go, which is  
4 why I encourage you to support Transitional Care of  
5 Lisle.

6 Also, as you know, no two individuals respond  
7 the same to an illness or to a therapy. Therefore,  
8 having treatment --

9 CHAIRWOMAN OLSON: Please conclude.

10 MR. GOODE: Therefore, having treatment options  
11 available for guests is very important, since no two of  
12 them are the same.

13 Thank you.

14 CHAIRWOMAN OLSON: Thank you.

15 MR. ITZKOWITZ: Good morning. My name is Alan  
16 Itzkowitz, I-T-Z-K-O-W-I-T-Z, and I'm a resident of  
17 Buffalo Grove, Illinois. I am here in support of  
18 Transitional Care of Lisle.

19 In 1985, at the age of 35, I was involved in a  
20 head-on collision caused by a 90-year-old man having a  
21 heart attack while driving. This resulted in limited  
22 damage to my left knee. Since the accident, the  
23 structure of the knee has continually deteriorated and  
24 osteoarthritis developed, along with bone-on-bone

1 condition.

2 After trips our family took over the years that  
3 involved a significant amount of walking and receiving  
4 three sets of injections to help improve the condition of  
5 the knee, I decided knee replacement surgery was the  
6 solution to eliminate the pain I had been living with.

7 After I made the decision to have the surgery  
8 and then stay at a rehabilitation facility, we started  
9 talking to my surgeon about what the recovery would be.

10 During that time, my wife found an article in  
11 the Northwest Suburban Chicago edition of the Daily  
12 Herald, announcing the opening of Transitional Care of  
13 Arlington Heights, a new short-term care facility.

14 I called right away and set up an appointment  
15 to visit the facility, along with other local rehab  
16 facilities, to find the best one to fit my needs.  
17 Together, my wife and I interviewed the management teams  
18 at the different facilities and chose Transitional Care,  
19 due to the staff we met during our visit, the comfort and  
20 security they showed throughout the facility, and its  
21 proximity to our home.

22 I spent three nights in the hospital after my  
23 knee replacement surgery in October 2015. I was the  
24 first guest at the Arlington Heights facility. When I

1 arrived there from the hospital, the staff was there to  
2 greet me and escort me to my room. From that point on, I  
3 saw the caring and professionalism of the entire staff,  
4 from the office staff to the nurses, nurse assistants,  
5 physical therapists, occupational therapists, social  
6 service staff, cuisine care staff, and the maintenance  
7 staff.

8 My rehab was scheduled for seven days. As a  
9 result of the topnotch care I received and the pace of  
10 the physical therapy team that I established, I went home  
11 after five days. With the progress that I made by being  
12 pushed and pushing myself, I was able to go home with  
13 only a cane and able to walk up and down the stairs.

14 I credit Transitional Care for help in getting  
15 me back on track.

16 Thank you for this opportunity to speak on  
17 behalf of Transitional Care of Lisle.

18 CHAIRWOMAN OLSON: Thank you, all.

19 Jeannie, the next five?

20 MS. MITCHELL: The last three for Transitional  
21 Care of Lisle, 15-056, are Marissa Kalama, Tim Wilsey,  
22 and Katie Lohr, and I will also call the first two for  
23 Transitional Care of Fox Valley, Project Number 16-002,  
24 and those two individuals are also -- are Randy Hertel

1 and, again, Alan Itzkowitz.

2 Again, please remember to spell and state your  
3 name for the court reporter and don't forget to sign in.

4 CHAIRWOMAN OLSON: So we're missing two. Are  
5 they not present? Can you say the names again?

6 MS. MITCHELL: The names are Marissa Kalama,  
7 Tim Winsley, Katie Lohr, Randy Hertel and Alan Itzkowitz.

8 I'll call one more person, Randy Fike.

9 MR. FIKE: I was called already.

10 MS. MITCHELL: Okay. There were several  
11 individuals that signed up to speak for both projects.

12 CHAIRWOMAN OLSON: If your testimony is the  
13 same, you can just tell us that, if it is. If it's not,  
14 that's fine.

15 Okay. Whoever this other person is, they've  
16 given up their opportunity.

17 Do you want to call one more?

18 MS. MITCHELL: Dana Trawczynski.

19 CHAIRWOMAN OLSON: Okay. Please proceed.

20 MR. WILSEY: Tim Wilsey, W-I-L-S-E-Y.

21 To the CON Board, I am here to oppose the  
22 project in Lisle, as an Alpha-Care Professional with over  
23 20 years of experience working in geriatrics within the  
24 Chicago area, and as a family member with loved ones in

1 need of rehab care.

2 As a family member, my aunt and personal friend  
3 received stellar compassionate care at Burgess Square  
4 Rehab in Westmont. From the nursing care and therapy  
5 team, to the accommodations, my aunt and close personal  
6 friends were treated as an extension of the care they  
7 received at the hospital prior to the rehab stay at  
8 Burgess.

9 As a professional, I have ten plus years as a  
10 Director of Business Development and as an Assistant  
11 Chief Operating Officer in both rehabilitation and  
12 continuing care retirement communities. The last ten  
13 years, I've been a consultant in operations and business  
14 development capacities for various senior communities and  
15 health care professionals.

16 In today's world of increased demands placed on  
17 rehabs of both the local and the federal levels, the area  
18 rehab communities here today with their projects work  
19 closely with hospitals to assure competent care,  
20 consistency, and a smooth transition for area geriatric  
21 patients and their families.

22 Medicare.gov in its rankings is often used as  
23 the benchmark for rehab communities to be compared to  
24 other competing communities. Physicians, hospitals,

1 referral sources and families, often use the star ratings  
2 to make a decision when deciding where their loved one  
3 will go.

4 In 2015, the Applicant applying for a bed had  
5 seven facilities with a one-star rating, and in 2016,  
6 five facilities with one-star rating. They had three  
7 facilities with a two-star rating in 2015, six in 2016  
8 with two stars. Three-star ratings, two facilities and  
9 one facility in 2016. Four star ratings, they had three  
10 facilities in 2015 and two in 2016.

11 MR. AGBODO: Two minutes.

12 CHAIRWOMAN OLSON: Your two minutes are up.

13 MS. KALAMA: Hello. My name is Marissa Kalama  
14 and I am from Chicago, Illinois. I am here in support of  
15 Transitional Care of Lisle.

16 I became involved with transitional care  
17 through an administrative preceptorship while earning my  
18 Masters in Healthcare Administration from the University  
19 of Illinois-Chicago.

20 Based on the knowledge that I gained through my  
21 studies and my experience working in skilled nursing  
22 facilities, I can say, without a doubt, that there is a  
23 need for transitional care centers in Illinois.

24 The unique and innovative approach that

1 transitional care takes in providing short-term  
2 rehabilitation is unlike any other service provided in  
3 the Illinois market. These centers meet the needs of  
4 those who require post-acute care but fear a nursing  
5 home, and of those who are looking for rehab in a  
6 purpose-built, dedicated, recovery-driven environment.

7 Through conversations I've had with patients  
8 who are in need of post-acute care, I hear an  
9 overwhelming desire to avoid going to a traditional  
10 nursing home for rehab. Sometimes people express that  
11 they've had bad experiences at nursing homes with a loved  
12 one in the past or feel they are truly not in need of  
13 nursing home care. Regardless, consumers are clearly  
14 looking for options.

15 Transitional care emphasizes returning guests  
16 home safely and in a timely manner. It is my belief that  
17 the Illinois health care market and those who require  
18 post-acute rehabilitation have a need for transitional  
19 care centers that is not being met by existing providers,  
20 which is why I support Transitional Care of Lisle.

21 CHAIRWOMAN OLSON: Thank you.

22 MR. HERTEL: Good morning. I'm Randy Hertel of  
23 Hawthorn Woods, Illinois. Last time I didn't spell my  
24 last name for you -- it's spelled H-E-R-T-E-L -- and I

1 support Transitional Care of Fox Valley for the same  
2 reasons I support Arlington Heights and Lisle.

3 CHAIRWOMAN OLSON: Thank you.

4 MR. ITZKOWITZ: My name is Alan Itzkowitz,  
5 I-T-Z-K-O-W-I-T-Z.

6 I am here to support Transitional Care of Fox  
7 Valley for the same reasons that I support Transitional  
8 Care of Lisle.

9 CHAIRWOMAN OLSON: Thank you.

10 MS. TRAWCZYNSKI: Dana Trawczynski, and I also  
11 support Transitional Care of Fox Valley for the same  
12 reasons that I support Transitional Care of Lisle.

13 CHAIRWOMAN OLSON: Thank you.

14 MR. FIKE: I am Randy Fike, F-I-K-E, and I  
15 support Transitional Care of Fox Valley for the same  
16 reasons I referenced earlier.

17 CHAIRWOMAN OLSON: Okay.

18 The next five, please?

19 MS. MITCHELL: The next five are Fred  
20 Berkovits, Chrissy Miller, Renée Garvin, Rosemary  
21 Angsten, and Larry Banks.

22 Again, please remember to state and spell your  
23 name for the court reporter and don't forget to sign in.

24 CHAIRWOMAN OLSON: Somebody can start, whoever

1 has the microphone.

2 MS. GARVIN: Hi. My name is Renée Garvin,  
3 G-A-R-V-I-N, and I just wanted to add to the comments  
4 that I previously shared in opposition for Transitional  
5 Care of Fox Valley.

6 I just want to reinforce that this model of  
7 care is currently available. There are providers in the  
8 planning area that do provide hospitality, sophisticated  
9 medical care, in a warm and inviting environment.

10 I think that the biggest issue that we have is  
11 the changing market where folks are not staying in  
12 skilled nursing for the same timeframe that they used to.

13 Just a simple example: The average length of  
14 stay in our community was 30 days. Now, we're down below  
15 15 days. So what that means is that you need double the  
16 number of admissions to maintain that same level of  
17 occupancy.

18 We're seeing markets change significantly  
19 because of accountable care, and so we need to think  
20 about how that's going to impact the future and how we  
21 will develop new service -- truly new service lines to  
22 meet the needs.

23 So thank you again in opposition of  
24 Transitional Care of Fox Valley.

1 MS. ANGSTEN: Good morning. Rosemary Angsten,  
2 A-N-G-S-T-E-N.

3 Good morning. My name is Rosemary Angsten.  
4 I'm the Senior Vice President of Sales and Admissions for  
5 Symphony Post Acute Network. I represent two skilled  
6 nursing facilities within the Fox Valley Market, Symphony  
7 at the Tillers and Symphony at Orchard Valley.

8 I'm here to oppose the project for several  
9 reasons, but mainly because the executive summary really  
10 inaccurately portrays the Fox Valley Market for  
11 post-acute care. I'd like to briefly share a few facts  
12 with you.

13 First of all, the proposal stated that the new  
14 project would have higher nursing staffing ratios than  
15 traditional nursing homes. Well, according to CMS.gov --  
16 I'll use one building as an example, one of my buildings,  
17 Symphony at the Tillers -- we run 3.3 times the national  
18 average for RN staffing, and as I did research rarely  
19 found that most of the skilled nursing facilities in the  
20 market run over the national average. High staffing  
21 ratios are already being met in the area.

22 The proposal states the new project would  
23 equate to better quality care. As rated by CMS, our two  
24 buildings alone are rated four- and five-star facilities.

1 In fact, out of 14 closest skilled nursing facilities in  
2 the area, nine of them are four and five stars. A newer  
3 physical plant does not equate to higher quality care.

4 And, finally, instead of making this about  
5 patient choice, realize a facility solely dedicated to  
6 short-term rehab would need to skim virtually all of  
7 these types of patients from all of the facilities in the  
8 area. What this would do to the other facilities would  
9 be so impactful they would have to become Medicaid  
10 facilities only; they would have to cut costs through  
11 staffing and facility renovations, which would affect the  
12 long-term population, which is such a fragile population.

13 On a very personal note, last week my dad had  
14 to admit to a nursing home, and I live in the Arlington  
15 Heights area and I told him not to send him to TCM. I  
16 think the reputation and some of the service failures  
17 have really proven that, as a family member, I did not  
18 trust to have him at that facility.

19 CHAIRWOMAN OLSON: Thank you.

20 MR. BERKOVITS: Fred Berkovits,  
21 B-E-R-K-O-V-I-T-S.

22 I spoke earlier, and I am a Regional Director  
23 of Operations for Bria Health Services. I am here on  
24 behalf of Bria of Geneva.

1           For the same reasons that I oppose the Lisle  
2 project, I oppose this project as well.

3           In the interest of expediency, I will not  
4 repeat my previous comments. Rather, I will try to focus  
5 on certain key points that I did not raise previously.

6           Our census in Geneva, which is a 107-bed  
7 skilled facility, is less than 80 percent. If any of our  
8 facilities in the surrounding area wish to increase beds,  
9 then under the ten percent rule, we could add over 500  
10 beds to the existing community with the stroke of a pen.  
11 Yet, why haven't any of these facilities done that?  
12 Because there is simply no need.

13           After hearing the comments of those in favor of  
14 the project, I'm confident to state that we, as well as  
15 our competitors, provide the exact same services as those  
16 proposed.

17           We, too, provide cardiac rehab, telemetry, a  
18 CHF program, nephrology. We even provide aquatic therapy  
19 in our Westmont facility.

20           As stated by one of the other persons, length  
21 of stay is declining, which is further shrinking the  
22 market, and the only way this project works is if they  
23 get virtually all of the area's short-term rehabilitation  
24 patients, and the impact on health care delivery would be

1 devastated.

2 The short-term rehabilitation patient is  
3 necessary not only for the viability of our facility, but  
4 also for the viability of the necessary long-term care  
5 needed in the community.

6 In addition, we've experienced staffing issues  
7 in our communities. Recruiting and retaining quality  
8 CNAs and nurses is a major challenge. Where is their  
9 staff going to come from?

10 MR. AGBODO: Two minutes.

11 MR. BERKOVITS: Thank you.

12 CHAIRWOMAN OLSON: Thank you.

13 MS. MILLER: Hi. My name is Chrissy Miller,  
14 M-I-L-L-E-R, and I am the Nurse Liaison and Director of  
15 Business Development for the group at Fox Valley and I do  
16 oppose the project.

17 I have been dedicated to serving this community  
18 for the last ten years providing quality health care  
19 services. The proposed project is simply a duplication  
20 of services that the community is already being provided.

21 My facility has a multimillion dollar recently  
22 renovated separate unit, with 36 private rehab suites in  
23 a modern setting, equipped with seven-day-a-week therapy,  
24 concierge services, and health education sessions.

1           We, too, have many successful short-term rehab  
2 stories, but we also have the joy of sharing many success  
3 stories of those receiving long-term care from us.

4           The proposed project would seem to ignore the  
5 current needs of our community by denying access to  
6 health care for Medicaid patients, as well as long-term  
7 nursing care patients.

8           Health care facilities should not only limit  
9 access to those who can generate the most revenue. The  
10 current providers are not having any difficulty admitting  
11 patients, as there are plenty of beds available, and  
12 adding another facility will only increase the current  
13 struggle for census that other providers have.

14           This overall low census of current quality  
15 health care facilities does not support the notion that  
16 more beds are needed in this area. If the community  
17 needed more beds, we would add them. We have not added  
18 them because we do not need them. It is apparent to  
19 myself and the other health care providers represented  
20 today that this project, there's just no need in our  
21 current market for a transitional care type project for  
22 us.

23           Thank you.

24           CHAIRWOMAN OLSON: Thank you.

1 MR. BANKS: Hello. My name is Larry Banks,  
2 B-A-N-K-S. I'm the Administrator of Community Nursing  
3 and Rehab.

4 I spoke earlier in opposition to the previous  
5 project and I'm speaking again as both projects are  
6 identical, other than the fact that one is on the east  
7 side of Naperville and the other is on the west side of  
8 Naperville, just a few miles apart.

9 Today is not about if Transition Care of  
10 Arlington Heights should be approved, it is about a lack  
11 of need for this project in our community.

12 It's also not about that Transitional Care  
13 would be licensed as a short-term rehab center. They  
14 will not. They'll be licensed as all the rest of us are,  
15 as a skilled nursing facility, and that is how they will  
16 appear when they are given to the people in the hospital.  
17 They are not going to be special. They are simply  
18 another skilled nursing home, and, therefore, will be  
19 like the rest of us.

20 There is no reason to add a new facility, let  
21 alone two facilities, before even a recently opened  
22 facility in our area is at its utilization standard, and  
23 this has not happened, and according to their testimony,  
24 may not happen. Yet, we're looking at adding another

1 facility to our area, which will already take those  
2 patients that allow the rest of us to financially be  
3 viable.

4 A few years ago, a similar project submitted by  
5 this Applicant in this exact area was already denied by  
6 the Board, due to the underutilization of the area  
7 facilities. No argument nor any evidence has been  
8 provided to explain why this Board shouldn't deny this  
9 project as well.

10 I respectfully ask the Board to deny  
11 Transitional Care's application, as it would have a  
12 devastating impact on the facility, as well as duplicate  
13 services already being provided by our facilities and  
14 many other high-quality facilities in the area of  
15 Naperville.

16 Thank you.

17 CHAIRWOMAN OLSON: Thank you.

18 Next five?

19 MS. MITCHELL: The next five also here for  
20 Transitional Care of Fox Valley are Tom Nelson, Heidi  
21 Reich-Aguilar, Lisa Henderson, Brianne Zitko, and Julia  
22 Buchler.

23 CHAIRWOMAN OLSON: Thank you.

24 MS. REICH-AGUILAR: My name is Heidi

1 Reich-Aguilar, R-E-I-C-H, hyphen, A-G-U-I-L-A-R.

2 I am in full support of Lisle and Fox Valley  
3 for reasons that I didn't hear today, those being, if I  
4 had a choice to go where I wanted to, to be taken care of  
5 the way I wanted to, I would choose transitional care.

6 CHAIRWOMAN OLSON: Thank you.

7 MS. HENDERSON: My name is Lisa Henderson and I  
8 am from Mt. Prospect. It's H-E-N-D-E-R-S-O-N.

9 My name is Lisa Henderson and I earned my MBA  
10 from Concordia University of Chicago with a concentration  
11 in health care management and have served as a marketing  
12 communications professional in the Chicago area for more  
13 than ten years.

14 Before starting my role as Director of  
15 Marketing and Business Development, I worked as a liaison  
16 for almost four years at a nursing home that strongly  
17 opposed the expansion of transitional care at both the  
18 CON and village hearings. After witnessing the work  
19 transitional care has done, I can say with absolute  
20 certainty that transitional care is a totally different  
21 concept than traditional nursing homes. Transitional  
22 care is the future of health care and offers a focus on  
23 providing post-acute care to a younger, growing  
24 demographic in a fresh and more hotel-like environment.

1 Transitional care blends both health care and hospitality  
2 in many ways with a progressive in-house therapy team, a  
3 unique culinary experience, and clinical care that  
4 consists of a higher and more intense level of nursing,  
5 and therapy with on-site physician management.

6 In my role, I have met a large amount of people  
7 who have never considered rehab in the past until now.  
8 These people will get better quicker and have a better  
9 chance of not returning to the hospital because of  
10 transitional care.

11 I also often hear things like, "I wish  
12 transitional care would have been here a year ago because  
13 I didn't want to go to a nursing home."

14 The bottom line is that many people don't see  
15 themselves rehabbing in a nursing home and desire an  
16 alternative. Transitional care is that alternative.

17 I have also witnessed case managers and other  
18 health care professionals, like physicians and surgeons,  
19 strongly support the transitional care concept because  
20 they are happy to offer an option that is an alternative  
21 to a typical nursing home.

22 In closing, I strongly encourage you to  
23 consider a health care model that is cutting edge,  
24 innovative, and has the ability to grow with and

1 accommodate to our future health care customer.

2 Please support Transitional Care of Fox Valley.

3 Thank you for your time.

4 MR. MORADO: Thank you.

5 MS. ZITKO: Brianne Zitko, B-R-I-A-N-N-E

6 Z-I-T-K-O, resident of Naperville, and I support

7 Transitional Care of Fox Valley for the same reasons as

8 stated for supporting the Lisle location.

9 CHAIRWOMAN OLSON: Thank you.

10 MS. BUCHLER: Julia Buchler, B-U-C-H-L-E-R,

11 from Chicago, Illinois.

12 I support Fox Valley for the same reasons that

13 I support Transitional Care of Lisle.

14 CHAIRWOMAN OLSON: Thank you.

15 MS. MITCHELL: There are six individuals left

16 to speak on Fox Valley. Will those individuals please

17 come up? They are Servilla S. Quinn, Mark Goode, Marissa

18 Kalama, Jackie Molen, Tim Wilsey and Jeff Schmidt.

19 Please remember to state and spell your name

20 for the court reporter and to sign in.

21 MS. QUINN: My name is Servilla Quinn,

22 Q-U-I-N-N. I am here in support of Fox Valley for the

23 same reasons as I support Lisle.

24 CHAIRWOMAN OLSON: Thank you.

1 MS. KALAMA: My name is Marissa Kalama,  
2 K-A-L-A-M-A, and I am here in support of Fox Valley for  
3 the same reasons I support Lisle.

4 CHAIRWOMAN OLSON: Thank you.

5 MR. WILSEY: My name is Tim Wilsey,  
6 W-I-L-S-E-Y. I spoke earlier in the Lisle project.

7 I'm opposing the project based on one point.  
8 In addition, the Applicant applying today has 16  
9 facilities in other states. Eleven of those facilities  
10 are classified by Medicare as below average or much below  
11 average. I oppose the project.

12 Thank you very much.

13 CHAIRWOMAN OLSON: Thank you.

14 MS. MOLEN: Good morning. My name is Jackie  
15 Molen. I am the Director of Marketing for the  
16 Meadowbrook Manor facilities in Bolingbrook, Naperville  
17 and LaGrange.

18 I would like it to be known that we are  
19 opposing the authorization of the proposed facilities.

20 There are currently a sufficient number of  
21 facilities and unoccupied beds to accommodate the needs  
22 of the short-term rehab population of this community.  
23 Local nursing homes are more than adequately prepared to  
24 accommodate such existing and future needs without

1 additional facilities.

2 It is common knowledge in the nursing home  
3 industry that the government's Medicaid program does not  
4 adequately fund the nursing home care to be able to  
5 provide a standard of care and the type of amenities most  
6 people desire without having a core base of Medicare  
7 insurance and private pay patients to supplement the  
8 meager revenue sources from Medicaid.

9 You will find that facilities such as  
10 Meadowbrook Manor enjoy a healthy mix of Medicaid and  
11 premium pay clients -- I'm sorry -- provide all patients  
12 with similar care amenities, regardless of their  
13 individual payer sources. The additional revenue that  
14 these premium pay clients provide enables the facility to  
15 offer staffing levels above minimum requirements. They  
16 support staff which helps our programming, such as  
17 cardiology, pulmonary, infectious disease wound care, and  
18 nephrology.

19 It is common knowledge in the nursing home  
20 industry the average occupancy in Illinois has been  
21 approximately 75 to 80 percent in recent years, in a  
22 market where the supply of beds already exceeds the  
23 demand. An addition of these proposed facilities will  
24 only serve to worsen the occupancy levels of the existing

1 facilities; thus, eroding the facility's ability to  
2 provide enhanced services for its clients. In some  
3 cases, it could even serve to force an existing operation  
4 out of business and the dislocation of many long-term  
5 residents.

6 We appreciate the fact the short-term client  
7 oftentimes prefers to disassociate themselves with the  
8 long-term care population and seek a modern, upscale  
9 environment. However, many facilities, including ours,  
10 Meadowbrook Manor, have been quite successful in  
11 providing a modern, well-appointed environment.

12 The addition of another facility that, in  
13 essence, would be duplicating services already available  
14 in the community would serve to exacerbate the existing  
15 shortness of staff.

16 CHAIRWOMAN OLSON: Please conclude.

17 MS. MOLEN: As plainly as I can put it, I am  
18 the one who fills the beds. The last thing we need is  
19 more beds dedicated to the short-term care patient.

20 Thank you for your attention.

21 CHAIRWOMAN OLSON: Thank you.

22 MR. SCHMIDT: Good morning. My name is Jeff  
23 Schmidt, S-C-H-M-I-D-T. I am a resident of Naperville,  
24 Illinois.

1 I am the Executive Director of Business  
2 Development for DuPage Medical Group, and I am here  
3 because we strongly support Transitional Care of Lisle,  
4 as well as Transitional Care of Fox Valley.

5 DuPage Medical Group is one of the largest  
6 primary care and specialty physician groups in Illinois,  
7 and we are committed to quality, efficiency, and access  
8 for all of our patients who live throughout DuPage, Kane,  
9 Will, and other suburban Cook counties.

10 DuPage Medical Group represents more than 550  
11 physicians and physician extenders, including nurse  
12 practitioners and physician assistants who work with us.

13 We manage or have risk for over 150,000 lives  
14 through our relationships with a variety of insurance  
15 companies. We see over 500,000 patients annually as  
16 their primary care physician or specialist.

17 I'm here today on behalf of DuPage Medical  
18 Group to support the development of both of the  
19 innovative health projects proposed in Lisle and Aurora,  
20 both of which are located in our primary service areas.  
21 The establishment of Transitional Care of Lisle and Fox  
22 Valley would provide better access and enhance our  
23 ability to meet our commitments to our patients and our  
24 at-risk partners.

1                   If DuPage Medical Group is to accomplish our  
2 goal of providing lower cost and higher quality health  
3 care, we need partners like Innovative Health to create  
4 transitional care centers that support our efforts.  
5 These proposed centers offer an approach that does not  
6 currently exist in the marketplace and they are part of  
7 the needed transformational change in the health care  
8 delivery system.

9                   We are excited to work together with Innovative  
10 and their new transitional care projects to ensure the  
11 residents of DuPage and other surrounding counties have  
12 access to lower costs, higher quality health care  
13 services, now and in the future.

14                   Thank you for your time.

15                   CHAIRWOMAN OLSON: Thank you.

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MS. MITCHELL: The remaining speakers are from the University of Chicago Medical Center Project, Project No. 16-008.

CHAIRWOMAN OLSON: One second.

I'll just remind the Board Members, since we do have plenty of members here, if you need to take a break, you can get up and go. We don't have to stop. We have nine.

Okay. Sorry to interrupt.

MS. MITCHELL: The first five are Veronica Morris Moore, Reverend Julie A. Less, Daniel Kaplan, Brian Malone, and Leslee Stein-Spencer.

Please remember to state and spell your name for the court reporter and don't forget to sign in.

CHAIRWOMAN OLSON: Somebody can go ahead and start.

MS. STEIN-SPENCER: I am Leslee Stein-Spencer, L-E-S-L-E-E, S-T-E-I-N, hyphen, S-P-E-N-C-E-R.

I am Director of the Medical Administration and Regulatory Compliance Division of the Chicago Fire Department. I am here in support of the proposal.

Our patients are significantly impacted by this distribution of specialty centers and facilities that

1 exist in the pockets of Chicago, which mainly include the  
2 South Side of Chicago. This creates a disparity of  
3 access to health care in the city.

4 Our trauma patients for the year 2015, we  
5 transported 5,775 patients across the city. If we look  
6 at our ZIP codes, 2,060 would have gone to the University  
7 of Chicago if they were a trauma center and had the beds  
8 available, but at this point, they still have a high  
9 number of bypassed hours. When hospitals are bypassed,  
10 our ambulances have to bypass that facility and go to  
11 another one.

12 I was here two years ago and testified, and  
13 even with the increased number of beds that they  
14 received, we still see a significant high rate for  
15 University of Chicago. In fact, they're one of highest  
16 in the city. Based on that, our trauma patients would  
17 not be able to go to that facility.

18 If we look at 2016, we have already transported  
19 2,465 trauma patients. Of those numbers, based on ZIP  
20 codes where the trauma occurred, 782 would have gone to  
21 the University of Chicago, if they were a trauma center  
22 and if they had an increased number of beds. Based on  
23 what we're seeing right now, we would not be able to  
24 transport the trauma patients to Chicago, but to other

1 hospitals across the city, thereby increasing our  
2 response times to the patients that are in need and our  
3 transport times.

4 Thank you.

5 CHAIRWOMAN OLSON: Thank you.

6 MR. MALONE: My name is Jawanza Brian Malone,  
7 J-A-W-A-N-Z-A, B-R-I-A-N, M-A-L-O-N-E.

8 On behalf of the Kenwood Oakland Community  
9 Organization, I'd like to voice my support for the  
10 University of Chicago Project.

11 After five years of our incident protests, we  
12 are pleased that the University has taken steps to listen  
13 to the voices in the surrounding community to reestablish  
14 the trauma unit that was closed nearly 30 years ago. We  
15 also encourage the University to continue to create  
16 spaces for the community to share its wealth and  
17 knowledge derived through generations of intrinsic issues  
18 with trauma and healing.

19 Thank you.

20 CHAIRWOMAN OLSON: Thank you.

21 REVEREND LESS: I'm Reverend Julie Less. I'm  
22 here to represent the Interfaith Leadership Council  
23 that's a part of the Trauma Center Coalition, as well as  
24 University Church and the Chicago Metropolitan

1 Association of United Church of Christ.

2 As a resident of the South Side since the 1970s  
3 and an alumna of the University of Chicago and a former  
4 chaplain at the University of Chicago Hospitals before  
5 there were trauma centers, when it was only a  
6 neighborhood hospital that did accept the traumas that  
7 came in, I understand the need.

8 We need a trauma center on the South Side  
9 that's close enough for an ambulance ride that's less  
10 than 20 minutes. It's necessary; it's needed.

11 As a representative of faith communities,  
12 especially the United Church of Christ, which has a  
13 historical mission to advocate for health care, I  
14 strongly urge you to accept this proposal and to allow us  
15 on the South Side to be able to be brought to a hospital  
16 in less than 20 minutes.

17 There are residents that just arrived. I'm  
18 going to ask them to stand and support this proposal.  
19 Those who just came on the bus from Chicago, please  
20 stand.

21 (Applause.)

22 REVEREND LESS: Thank you.

23 CHAIRWOMAN OLSON: Thank you.

24 MR. KAPLAN: My name is Daniel Kaplan. I'm a

1 community organizer with the Jewish Council on Urban  
2 Affairs and I'm speaking today in support of Project  
3 16-008.

4 The Jewish Council on Urban Affairs is a part  
5 of the Trauma Care Coalition, which was started by  
6 Fearless Leading by the Youth and Southside Together  
7 Organizing for Power, which represents black community  
8 organizing on Chicago's South Side.

9 Since 2010, this coalition has been calling for  
10 the University of Chicago to open a Level I adult trauma  
11 center, as there are no trauma centers on the South Side.

12 One of their youth leaders, Damian Turner, was  
13 shot on 61st and Cottage Grove, two blocks from the  
14 University of Chicago, in 2010. He was taken to  
15 Northwestern, nearly ten miles away, and died en route.

16 For the past five years, the coalition has been  
17 organizing to bring the University to take action, and  
18 it's because of that perseverance and vision from black  
19 neighborhood organizations and particularly black youth  
20 that we're here today and that the University is  
21 recognizing the need for a trauma center as this  
22 coalition has since 2010.

23 Now that we're here today, we ask that you, the  
24 Board as well, recognize and understand the need for a

1 trauma center on the South Side after nearly 30 years of  
2 an absence of a South Side Trauma Center.

3 This is truly an urgent and necessary proposal  
4 and we ask that you support it, so that way, we can have  
5 a South Side Trauma Center.

6 CHAIRWOMAN OLSON: Thank you.

7 Next, please.

8 MS. MORRIS MOORE: My name is Veronica Morris  
9 Moore. I am here to support the Project 16-008 of the  
10 University of Chicago Medical Center. I'm one of the  
11 young people that help founded this campaign when it  
12 first started after Damian Turner was shot in August.

13 It took five years and a lot of physical and  
14 mental and emotional sacrifice to get the University of  
15 Chicago to where it is today, and at this point it's in  
16 the hands of this Board, but not just this Board, maybe  
17 the institutions that have the responsibility to address  
18 the crisis in the black community in Chicago, and that's  
19 basically why I'm here.

20 As I said, I support this project, but to also  
21 say why it's important to the black community.

22 There have been countless thousands of lives  
23 that have been lost through the gun violence, and there  
24 are institutions that come on the South Side that grow

1 and develop while black people continue to die on the  
2 South Side.

3 So, for those reasons, this project needs to be  
4 approved and it needs to be also pushed, not just through  
5 this Board, but also through the University of Chicago  
6 continuing to hold this up in a way that honors the  
7 community and not just one that's important for them to  
8 meet the community and show good faith, but really to  
9 listen to and care about the people of the community and  
10 what they need for their own lives.

11 And so that is why I'm here, and that's why  
12 I'll continue to be here, and that's why I'll continue to  
13 be resilient in this fight in holding my only share of  
14 peace for this community, both for the issue of the  
15 Trauma Center Campaign and for other issues that the  
16 University of Chicago and many other institutions have  
17 access to the type of resources that black people who are  
18 suffering on the South Side of Chicago need.

19 (Applause.)

20 CHAIRWOMAN OLSON: Thank you.

21 Could we have the next five, please?

22 MS. MITCHELL: The next five are Charles  
23 Holland, Tim Caveney, Tim Egan, Verneda Bachus, and  
24 Dr. Linda Druelinger. I apologize if I'm butchering

1 anyone's name.

2 Please remember to state and spell your name  
3 for the court reporter and sign in.

4 MR. EGAN: My name is Tim Egan, E-G-A-N, and  
5 I'm the CEO and President of the new Roseland Community  
6 Hospital.

7 I'd like to take a moment to highlight how  
8 extraordinary it is that I'm here before this Board to  
9 support UChicago's proposal.

10 The fact that I'm joined by other local  
11 healthcare leaders, asking you to pass a larger medical  
12 center's expansion plan is noteworthy, and it underscores  
13 the unique space that UChicago Medicine occupies on the  
14 South Side.

15 The new Roseland is dedicated to providing the  
16 highest quality of care to our surrounding community.  
17 When a case reaches a certain level of complexity or  
18 requires specific specialty care, we rely on other health  
19 care partners to ensure that our patients get the  
20 comprehensive care they require. Once the patient  
21 receives that care, they transfer back to the new  
22 Roseland.

23 UChicago Medicine should be at best equipped to  
24 handle the most complex cases in our planning area, yet

1 their capacity constraints strain our network of care and  
2 negatively impact community hospitals like the new  
3 Roseland. These constraints cause EMS drivers to be  
4 rerouted to other hospitals, even when UChicago Medicine  
5 might be the best choice for the patient, and they limit  
6 our ability to transfer the patients most in need of  
7 complex care.

8 UChicago Medicine's Get CARE plan addresses  
9 these constraints. It also addresses the South Side's  
10 desperate need for trauma care, where almost 50 percent  
11 of trauma cases occur. If someone is injured on the  
12 South Side of Chicago, time should be not be wasted by  
13 traveling many miles away to receive trauma treatment.

14 (Applause.)

15 Our city is made stronger when patients can  
16 access the type of care they need, when they need it, in  
17 their own backyard.

18 Most importantly, UChicago Medicine has  
19 presented a credible, sustainable plan to ensure that  
20 South Side trauma cases can receive the advanced care  
21 they require for years to come.

22 I support Get CARE because it is a long-term  
23 solution that will lead to a stronger, more integrated  
24 system of care on the South Side. I urge this Board to

1 do the same.

2 Thank you.

3 (Applause.)

4 CHAIRWOMAN OLSON: Thank you.

5 MR. HOLLAND: Good morning. My name is Charles  
6 Holland, H-O-L-L-A-N-D, and I'm President and CEO of  
7 St. Bernard Hospital, safety-net community hospital  
8 serving Englewood and other South Side Chicago  
9 communities, and I support this proposal.

10 My hospital is located at the Dan Ryan  
11 Expressway and 64th Street, a mere two and a half miles  
12 distance, though at times a world away from the  
13 University of Chicago Medical Center. We serve an  
14 economically distressed population burdened by violence  
15 and the cumulative effects on health by decades of  
16 poverty. Nearly 70 percent of the patients seen at  
17 St. Bernard have Medicaid as their source of payment.  
18 Patients come to us with chronic diseases, congestive  
19 heart failure, pneumonia, behavioral and other health  
20 issues that do not require the kind of higher level, more  
21 expensive care provided by the University of Chicago  
22 Medical Center. Yet, it is vitally important that our  
23 patients who need more specialized care for complex  
24 conditions have easy access to that care. Those same

1 patients then come back to our hospital and our community  
2 providers for follow-up care.

3 It makes practical sense that it should be  
4 easier for my hospital to transfer and refer patients who  
5 need tertiary care to the nearest available institution  
6 that provides that care. Yet, our experience has been  
7 the majority of time accessing a complex care bed at UCMC  
8 is not possible because beds are not available. We then  
9 need to transfer patients to a tertiary center outside of  
10 our community.

11 Likewise, Level I trauma care is needed in our  
12 community on the South Side where nearly half of  
13 Chicago's adult trauma cases originate.

14 To ensure that my hospital and our communities  
15 have appropriate access to complex care, cancer care, and  
16 trauma beds, I support the application of the University  
17 of Chicago Medical Center's Get CARE strategy. This  
18 strategy will make certain that all our patients who need  
19 higher level care will get that care at the nearest  
20 tertiary care facility.

21 We look forward to further working with UCMC in  
22 developing a model of collaborative health care for the  
23 South Side that will improve access to a continuum of  
24 quality care. This should allow community hospitals to

1 provide care that they best know how to provide, while  
2 ensuring local access to tertiary care.

3 Thank you.

4 CHAIRWOMAN OLSON: Thank you.

5 MS. BACHUS: Good morning. My name is Verneda  
6 Bachus, V-E-R-N-E-D-A, B-A-C-H-U-S, and I am the Chief  
7 Executive Officer of Friend Family Health Center. My  
8 team and I provide primary and preventive health care  
9 services to the vulnerable and medically underserved  
10 population of Chicago's southeast and southwest sides.

11 Every day we see the toll that the lack of  
12 adequate health care has taken on our neighbors.  
13 Patients on the South Side have unique health care needs,  
14 but over the years, there have been fewer and fewer  
15 resources available to help them.

16 African-Americans, in particular, on the South  
17 Side of Chicago suffer from higher overall incidences of  
18 cancer and cardiovascular disease than the rest of  
19 Illinois.

20 At Friend Family Health Center, if a patient  
21 needs complex services like specialty or cancer care, we  
22 work with the University of Chicago Medicine to make sure  
23 that their health is in the best hands. However, when  
24 UCM is at capacity, our patients must wait until a bed is

1 available or travel to a faraway hospital.

2 The patients that we serve deserve access to  
3 quality complex care in their home community without  
4 worrying that the hospital most equipped to help them  
5 will be unable to do so. They don't have time to waste.

6 The Get CARE plan addresses the needs of the  
7 community by converting Mitchell Hospital into a  
8 dedicated cancer center, as well as renovating and  
9 expanding the emergency department to decrease wait  
10 times.

11 I, along with the staff and Board of Directors  
12 of Friend Family Health Center, strongly support the Get  
13 CARE plan, and I ask you, the Board, to do the same.

14 Thank you.

15 (Applause.)

16 CHAIRWOMAN OLSON: Thank you.

17 MS. DRUELINGER: My name is Linda Druelinger,  
18 D-R-U-E-L-I-N-G-E-R. I'm the Chief of Emergency Medicine  
19 at the University of Chicago, and I can tell you, I worry  
20 every day about the limited capacity we have to care for  
21 our patients in the emergency department and in our  
22 hospital.

23 We've seen a tremendous increase in the number  
24 of patients coming to our emergency department for care

1 over the past five years. Because of our capacity  
2 constraints, over 5,000 patients who come to us this year  
3 will leave without being seen. The majority of patients  
4 who come to our emergency department are patients that  
5 have potentially life-threatening or urgent conditions.  
6 25 percent of the patients we see need to be admitted.

7 Because our hospital is near or at full  
8 capacity almost every day, over half of the beds in our  
9 emergency department are frequently occupied by admitted  
10 patients waiting for a bed. Our admitted patients wait  
11 upwards of ten hours or more for a bed.

12 Let me share a personal story about what these  
13 numbers actually mean to me.

14 Earlier this year, we had an elderly patient  
15 who I'll call Sophie, who came to the emergency  
16 department with her daughter. They came on a day when we  
17 were completely full. Sophie was sick, confused, and in  
18 pain, and she had a long wait in our waiting room just to  
19 see a physician. After she was seen, it was clear she  
20 needed to be admitted, but our hospital was full so  
21 Sophie ended up having to spend the night in the  
22 emergency department waiting for a bed. You can imagine  
23 how disorienting this is for anyone, but especially for  
24 our elderly patients.

1           Afterwards, I got a call from Sophie's  
2 daughter, who was very disappointed and very angry. She  
3 said, "My mother and I were terrified. We both felt  
4 helpless. How can a hospital like the University of  
5 Chicago let this happen?"

6           My answer to her -- "we don't have enough  
7 room" -- is just not acceptable.

8           Sophie's story happens almost every day at  
9 UCMC.

10           I am here to be an advocate for our Sophies and  
11 their families. Our plan is to promise to every Sophie  
12 that University of Chicago Medicine will be there when we  
13 are needed the most. We can only do this if you approve  
14 our plan.

15           Thank you.

16           (Applause.)

17           CHAIRWOMAN OLSON: Thank you.

18           Good morning. My name is Tim Caveney, C-A, V  
19 as in Victor, E-N-E-Y. I'm the President and CEO of  
20 South Shore Hospital. We are a safety net hospital  
21 located on the southeast side of Chicago about five miles  
22 away from the University of Chicago Medical Center.  
23 Annually, we admit about 3,600 patients and treat about  
24 16,000 patients in our emergency room.

1           At South Shore, we strive to provide the  
2 highest level of care to our patients, but sometimes our  
3 patients require more complex care from University of  
4 Chicago Medicine. Typically, we transfer over 500  
5 patients a year to other institutions for this type of  
6 care, but because of its capacity constraints, the  
7 University of Chicago Hospital simply does not have the  
8 beds available for patients from hospitals like mine in  
9 need of that specialty care.

10           A recent case at South Shore Hospital  
11 underscores the problem. A patient arrived in our  
12 emergency department with a life-threatening condition.  
13 After our dedicated team of emergency specialists  
14 stabilized the patient, it was clear to us that the  
15 patient needed to be transferred to more complex care  
16 than we could offer in our institution.

17           I later learned that the patient was  
18 transferred to a hospital that is over 15 miles and a  
19 half hour drive away on a good day. I asked my emergency  
20 department staff why we didn't transfer the patient to  
21 University of Chicago Medicine, which is much closer to  
22 our facility and more convenient for our patients. I was  
23 shocked when my staff told me that they didn't even  
24 consider University of Chicago because they never have

1 available beds for our patients.

2 Frankly, this patient deserved more. All South  
3 Side patients deserve more. University of Chicago's bed  
4 expansion is necessary for hospitals like mine to provide  
5 our patients with the care they need and deserve.

6 The future of our community's integrated web of  
7 care now rests in the hands of the Illinois Health  
8 Facilities and Services Review Board. I trust they will  
9 hear the needs of our community, and I urge you to  
10 approve University of Chicago Medicine's comprehensive  
11 plan.

12 Thank you.

13 (Applause.)

14 CHAIRWOMAN OLSON: Thank you.

15 MS. MITCHELL: The next five are Dr. Blase  
16 Polite, Dr. Daneen Woodard, Roger Huff, Kathy Huff, and  
17 Francine Washington.

18 Again, please remember to state and spell your  
19 name for the court reporter and to sign in.

20 UNKNOWN SPEAKER: Kathy Huff is not here.

21 CHAIRWOMAN OLSON: Do you want to call one  
22 more?

23 MS. MITCHELL: Eddie McKinnie, please come  
24 up -- or Ed McKinnie.

1 CHAIRWOMAN OLSON: Go ahead. Somebody can  
2 start, anybody. You all have the mics.

3 MS. WASHINGTON: My name is Francine  
4 Washington. I'm President of the Central Advisory  
5 Council. I have a script, but I don't need a script. I  
6 can talk off the top of my head.

7 As President of the Central Advisory Council,  
8 I'm responsible for 25,000 public housing units, as well  
9 as 44,000 Section 8 voucher holders. That means I have  
10 like 150,000 people that I'm responsible for, and we need  
11 a trauma center.

12 The University of Chicago is -- I want to take  
13 an opportunity to tell you about this. Several months  
14 ago, me and my sister walked right down 15th and Cottage  
15 Grove. An ambulance was going at a high speed and all of  
16 a sudden stopped. My sister said, Why did he stop in the  
17 middle of the street? Why didn't he just pull into the  
18 emergency door? I said, Because it's a trauma case. He  
19 cannot dare go into the emergency room at the university.  
20 He had to take him all the way to County.

21 My sister says, You know what? With all our  
22 bumpy streets and roads from the South Side to the  
23 County, this person's gonna die. It don't make no sense  
24 you can't take him right across the street into an

1 emergency room or a trauma center.

2 We need the trauma center, not just for  
3 African-Americans, people of color. We're dying every  
4 day -- not just from gunshots. We have so many  
5 diabetics, so many cancer patients. What about us? Who  
6 cares about us? Nobody but us?

7 If you had to walk in our shoes every day  
8 watching the ambulance go by, you could walk right across  
9 the street and you could roll out your bed to the  
10 university, but yet still you can't go to the university  
11 with some emergency medical, like a trauma. How does  
12 that sound? I can roll out on my bed and can't get  
13 there. We've got to take it way to the other side of  
14 town. By the time I get halfway there, I'm dead. We  
15 lose a lot of folks, young folks and old folks, that  
16 should still be here.

17 The university is a great medical facility. At  
18 one time, we had to fight to get into the emergency room.  
19 Now they let us in and give always quality care. Now we  
20 have to fight to save our lives.

21 We love that we want to live. Life is for  
22 those who love to live, but we on the South Side, the  
23 cost of living is going up and the care is going down.

24 CHAIRWOMAN OLSON: I need to you to conclude

1 when your two minutes is up.

2 MS. WASHINGTON: My conclusion is, when it  
3 comes to the trauma center, if we don't get one on the  
4 South Side, the cost of living will surely go up. The  
5 cost of living is going up and people are dying. We need  
6 a trauma center.

7 (Applause.)

8 CHAIRWOMAN OLSON: Thank you.

9 MR. POLITE: Blase, B-L-A-S-E, Polite,  
10 P-O-L-I-T-E.

11 I want to thank the Board for giving me this  
12 opportunity to speak to the critical importance of  
13 increasing the capacity of only National Cancer Institute  
14 Comprehensive Cancer Center on the South Side of Chicago.

15 I am the primary colorectal cancer oncologist  
16 at the University of Chicago and the chief quality  
17 officer for cancer. I've also spent the last 13 years  
18 with a primary research focus on cancer health  
19 disparities.

20 As cancer survival has improved nationwide,  
21 Chicago's South Side communities have seen these  
22 disparities increase significantly.

23 It is important to hear the statistics, but I  
24 always remember that these number represent somebody's

1 mother, father, brother, sister, or child.

2 (Applause.)

3 An African-American woman is 40 percent more  
4 likely to die from breast cancer in Chicago than a white  
5 woman. If she lived in New York City, she would only be  
6 five percent more likely to die.

7 An African-American man on the South Side of  
8 Chicago is 70 percent more likely to die from colon  
9 cancer compared to the rest of the country.

10 One of the major contributing factors for the  
11 disparity is a lack of access to highly specialized  
12 cancer care. When you hear in testimony that our  
13 hospital is 100 percent full for almost half of the year,  
14 this means that when I get a call from one of my  
15 colleagues on the South Side asking for assistance, I  
16 cannot get the newly diagnosed lymphoma or leukemia  
17 patient into our hospital to start the highly specialized  
18 therapy that they need.

19 That's why the Get CARE plan is so important.  
20 It will dramatically increase access to the types of care  
21 our community needs the most. The plan is bold because  
22 the needs are great. Under Get CARE, we will develop a  
23 more integrated system of care where patients can move  
24 seamlessly and with ease through the system as their

1 specific needs for care change, bringing us one step  
2 closer to eliminating cancer health disparities on  
3 Chicago's South Side.

4 The need is great and the challenge is stark.  
5 Approval of this certificate of need would allow us to  
6 expand our capacity to serve the clear and present needs  
7 of our community with the highest level of specialized  
8 patient care.

9 With your help, we believe we can be a model  
10 for the nation in how tremendous advances in cancer care  
11 can be shared by all people, regardless of race,  
12 ethnicity, socioeconomic status, or zip code.

13 (Applause.)

14 CHAIRWOMAN OLSON: Thank you.

15 MR. MCKINNIE: Good morning. My name is Edward  
16 McKinnie, M-C-K-I-N-N-I-E, President of Black Contractors  
17 United, the oldest construction advocacy organization.  
18 We represent the entire range of construction trades,  
19 suppliers and security.

20 Thank you for allowing me to speak on behalf of  
21 University of Chicago Medicine's plan to increase access  
22 to emergency and specialty health care for an area where  
23 it is desperately needed.

24 I know firsthand of such medical needs. On

1 January 7, 2015, I was rushed to the emergency room with  
2 a pulmonary embolism with 85 percent blockage in both  
3 lungs as a result of a knee surgery. Through the grace  
4 of God and great emergency care, I stand before you here  
5 today.

6 (Applause.)

7 Black Contractors United's members live, work,  
8 and are committed to the continued vitalization of our  
9 neighborhoods. UC Medicine is committed both from a  
10 business and medical perspective. Together, we work to  
11 make the surrounding communities prosperous and healthy.

12 Their plan will provide for a 269 million  
13 dollar investment in patient care and create more than  
14 1,000 permanent jobs and over 400 construction jobs, of  
15 which a significant number will be our members. We know  
16 this because of our past experience. The specialty care  
17 that UC Medicine provides will be greatly enhanced  
18 because of this project.

19 Jobs and a healthy environment are what keeps  
20 communities strong. So, please, I ask from a personal,  
21 business, and community perspective that you approve UC  
22 Medicine's plan.

23 Thank you.

24 (Applause.)

1 CHAIRWOMAN OLSON: Thank you.

2 MS. WOODARD: Good morning. I'm Dr. Daneen  
3 Woodard, W-O-O-D-A-R-D, and I'm here to represent Access  
4 Community Health Network, an organization of federally  
5 qualified health centers on the frontline of  
6 community-based health care.

7 For 25 years, we've provided a continuum of  
8 care, comprehensive by design, to best meet the needs of  
9 our communities. That care is critical to the lives of  
10 our patients, 74 percent of whom live below the poverty  
11 line. Our services are designed to address the health of  
12 underserved communities in areas such as preventive care,  
13 chronic disease management and support services.

14 On behalf of Access and the patients we proudly  
15 serve, I ask this Board to pass the Get CARE plan to open  
16 access to a comprehensive suite of services to a  
17 community that needs it.

18 The Get CARE plan will expand emergency care,  
19 reducing the chances that UChicago Medicine will go on  
20 bypass, and placing hope in the hands of those that need  
21 emergency services. The plan also addresses the need for  
22 access to trauma care in communities where 50 percent of  
23 trauma originates. These elements are a no-brainer.

24 As an internal medicine practitioner, I'm

1 excited about the possibility of greater access to  
2 high-quality critical preventive and treatment services  
3 for a community plagued by higher incidence of disease.

4 UChicago Medicine's plan for a dedicated cancer  
5 hospital and expanded cardiovascular services directly  
6 impacts South Siders and specifically addresses the needs  
7 of African-Americans who suffer disproportionately from  
8 cancer.

9 The Get CARE plan will provide access to trauma  
10 care and expanded emergency services and widen access to  
11 specialty and cancer care.

12 At Access, we're proud that our neighbors at  
13 UChicago Medicine have stepped up to the plate to improve  
14 quality health outcomes for our community.

15 On a personal level, I live on the South Side  
16 near University of Chicago, four blocks from where  
17 15-year-old Hadiya Pendleton was shot and killed.

18 For this reason and others, my family, my  
19 neighbors, Access and I are hopeful that you will pass  
20 the Get CARE plan.

21 CHAIRWOMAN OLSON: Thank you.

22 MR. HUFF: My name is Roger Huff, H-U-F-F. I  
23 strongly support UChicago Medicine's Get CARE plan.

24 The issue is personal. A few years ago, I

1 experienced what my wife thought was a stroke. The left  
2 side of my face had drooped. I was able to quickly get  
3 into the UCMC emergency department. The attending  
4 physician on duty reassured my wife and took charge of a  
5 team of six to eight professionals. A potential stroke  
6 requires fast action and that is what I received. It  
7 turned out I had Bell's Palsy and recovered with a month.

8 My wife and I are very grateful for the prompt,  
9 high quality, and caring attention that I received from  
10 UChicago Medicine that day.

11 Yet, this isn't the story for everyone who  
12 comes to the UChicago emergency department. You've heard  
13 the statistics regarding capacity and the impact on  
14 frequent bypass and high diversion rates.

15 We on Chicago's South Side are fortunate to  
16 have a major medical center in our own backyard; however,  
17 receiving essential medical care when needed shouldn't  
18 feel like winning the lottery. Access to health care is  
19 a basic right.

20 I am grateful that UChicago Medicine has heard  
21 the call of the community. It's put forth a plan to  
22 relocate and expand its ED, provide for Level I adult  
23 trauma care, along with all the other added capabilities  
24 set forth in its application.

1           Hyde Park residents and our South Side  
2 neighbors should no longer worry that you may be forced  
3 to wait for hours or travel across the city when a  
4 medical emergency strikes.

5           I urge the Board to approve the Get CARE plan  
6 as proposed by UChicago Medicine.

7                           (Applause.)

8           MS. MITCHELL: There are six individuals left.  
9 Please come up when you are called. Sandra Bivens, Salim  
10 Al Nurridin, Louanner Peters, Candace Henley,  
11 Dr. D. Kinney and Pastor Chris Harris.

12                          Please remember to state and spell your name  
13 for the court reporter and sign in.

14           CHAIRWOMAN OLSON: Somebody go ahead and start.

15           MS. BIVENS: Hello. My name is Sandra Bivens.  
16 I'm the Executive Director of the 51st Street Business  
17 Association in Washington Park and Grand Boulevard area.

18                          We strongly support the University of Chicago  
19 Medicine's plan to increase access to emergency and  
20 specialty health care on the South Side of Chicago. As  
21 an organization, we're always committed to recognizing  
22 any initiative that supports our business and our people  
23 in the community. Our community has a lot of strength,  
24 but it's also in need of strong investments from business

1 and health care perspectives.

2 Case in point: Henry English, Executive  
3 Director of the Black United Fund over a month ago was in  
4 an accident on Lake Shore Drive. He died on his way to  
5 Northwestern Hospital's trauma center when the University  
6 of Chicago was only a couple minutes away. We lost a  
7 great leader who would have probably been here testifying  
8 for the trauma center today if he was alive.

9 And more important about this project that the  
10 University of Chicago is performing, which is also close  
11 to his heart, is that it's a 269 million project, which  
12 means one thousand permanent jobs, and not just jobs in  
13 the kitchen, but from the doctors that are walking the  
14 floors to the people that clean the floors, there will be  
15 1,000 permanent jobs. There will be 400 construction  
16 jobs, and you're looking at our black contractors having  
17 an opportunity to actually be part of a big project like  
18 this.

19 We're also looking at the procurement of  
20 services that we expect the university to utilize our  
21 small businesses, from buying the toilet paper for the  
22 bathrooms to the toilets themselves.

23 The new plan will increase access to  
24 desperately-needed health services on the South Side

1 while investing in our local businesses and people, and,  
2 to us, this is a win for all.

3 (Applause.)

4 MS. HENLEY: Good morning. My name is Candace  
5 Henley. It's spelled H-E-N-L-E-Y. I'm a proud South  
6 Side resident and Trinity United Church of Christ  
7 parishioner and a colon cancer survivor.

8 Colon cancer hit my life like a hurricane, and  
9 I was left with devastation that hit every corner of my  
10 life; physical, mental, emotional and psychological. It  
11 took six months for me to be diagnosed with colon cancer.  
12 I was in and out of emergency rooms and visited various  
13 health care providers until I received my diagnosis and  
14 treatment I needed. It was almost too late. I lost 50  
15 pounds within nine days of my surgery to remove my large  
16 intestine. Feeling hopeless, I tried to commit suicide.

17 Thirteen years after this life-changing  
18 experience, I stand before you as the Founder of the Blue  
19 Hat Foundation, which is a faith-based colon cancer  
20 organization, whose mission it is to educate, raise  
21 awareness, and provide resources to minority and  
22 medically underserved communities. I survived but not  
23 everyone does.

24 Thirteen years after my diagnosis, there were

1 two South Side women like myself who lacked access to  
2 quality cancer care and suffered as a consequence.

3 Cancer rates on the South Side of Chicago are  
4 11 percent higher than the Illinois average and a full 25  
5 percent higher than the U.S. average. I know this all  
6 too well, these higher rates are often caused by delayed  
7 diagnosis and lack of access to direct treatment.

8 I'm fed up with these statistics. My neighbors  
9 and I deserve access to higher quality care and cancer  
10 treatment when needed and where needed.

11 We have a devastatingly high supply of cancer  
12 patients on the South Side of Chicago and a  
13 world-renowned medical center wanting to meet that demand  
14 by building a dedicated cancer hospital in our midst.

15 No one should have to face the hurricane of  
16 cancer like I did, and I urge you to, like me, support  
17 the Get CARE plan of the University of Chicago.

18 Thank you.

19 (Applause.)

20 MS. KINNEY: Good afternoon. My name is  
21 Dr. Deleshia Kinney. That's spelled D-E-L-E-S-H-I-A.  
22 Last name Kinney, K-I-N-N-E-Y.

23 I'm here to represent the South Shore Planning  
24 and Preservation Coalition. We are a community-based

1 collaboration of diverse organizations, businesses,  
2 residents, and concerned stakeholders, united to serve as  
3 a catalyst to improve the quality of life within the  
4 South Shore community. We strongly support Proposal  
5 16-008.

6 On behalf of this diverse group of Chicagoans,  
7 I ask you to support the University of Chicago Medicine's  
8 Get CARE plan to bring equal access to Chicago's South  
9 Side.

10 My South Shore neighbors and constituents are  
11 increasingly concerned about the long-term care and  
12 economic wellbeing of our health in our community.

13 We all know that the health is one of the  
14 building blocks of a strong neighborhood, yet Chicago's  
15 South Side has been seeing a steady disinvestment in our  
16 communities.

17 While more than half of Chicago's trauma cases  
18 take place on the South Side, residents must cross the  
19 city to access the trauma care that they desperately  
20 need. We've also watched as the number of South Side  
21 hospital beds has been cut in half over the course of the  
22 past three decades, with major hospitals like Michael  
23 Reese closing their doors.

24 University of Chicago's Get CARE plan is more

1 than a hospital expansion. For South Siders, it's a  
2 renewed commitment to our community and a much-needed  
3 investment in our health and our wellbeing.

4 The Planning Coalition applauds the University  
5 of Chicago Medical for stepping up to provide the  
6 comprehensive care that the South Siders need. We need  
7 equal access to trauma, ER and specialty care services  
8 when we need them and where we need them.

9 We need the Illinois Health Facilities and  
10 Services Review Board to pass the Get CARE plan in its  
11 entirety.

12 Thank you.

13 (Applause.)

14 MR. AL NURRIDIN: Good afternoon. My name is  
15 Salim Al Nurridin, capital S-A-L-I-M, capital A-L,  
16 capital N-U-R-R-I-D-I-N.

17 I thank you for this opportunity to speak  
18 before this Board. I've been here before on a number of  
19 other projects and I know you always deliberate, and it's  
20 always pleasant to know that you really pay attention to  
21 what people are saying, as well as who's present.

22 I think it's remarkable that so many people  
23 came two hours to hear people speak for two minutes. I  
24 think it says a lot to the commitment and the fact that

1 this project is bringing community together.

2 The closing of the trauma center created a  
3 great split, but it is this new project that promises to  
4 bring us together with an opportunity to continue to move  
5 forward.

6 Two issues, actually three: First of all, I  
7 want to applaud the community, especially Dr. Abbots, for  
8 what she's doing and what she's done to bring us  
9 together.

10 (Applause.)

11 Then I want to thank the hospital's commitment  
12 to work with safety nets, because we know we need more  
13 than a trauma center, we need a trauma system, and I  
14 think that their commitment to work with our safety net  
15 hospitals means that any door you walk into, you can walk  
16 into the University of Chicago. That's a pleasant  
17 thought.

18 But, lastly, I want to compliment Sharon  
19 O'Keefe and her team because the reason we closed this  
20 was because it cost too much.

21 We need a financial business model that's going  
22 to sustain the hospital past this moment, and I think the  
23 cancer center, for all the good reasons that it does to  
24 produce health outcomes and the challenges of cancer in

1 our communities, it is a way in which to perpetuate a  
2 funding mechanism, so when our legislators can't figure  
3 out how to pass a budget, we don't have to worry about  
4 closing our trauma centers.

5 Thank you for these two minutes. I usually go  
6 over, but thank you for that.

7 (Applause.)

8 MR. HARRIS: Good morning. I'm Pastor Chris  
9 Harris, C-H-R-I-S, H-A-R-R-I-S. I'm the Founder and CEO  
10 of Bright Star Community Outreach, a nonprofit committed  
11 to strengthening vulnerable families and communities on  
12 the South Side of Chicago.

13 Let me cut to the chase. We had our 1,000th  
14 shooting in Chicago a few weeks ago. Four months into  
15 2016, unfortunately, we've already lost close to 200  
16 lives due to violence, violence that is  
17 disproportionately happening on the South Side of  
18 Chicago.

19 It is unconscionable that South Side residents  
20 live in a community that sees some of the highest rates  
21 of violence and traumatic injuries; yet, there is no  
22 Level I adult trauma center. The need in our community  
23 is so clear, so obvious, and yet, we have waited for  
24 decades for our need to be met.

1           Through all of this, my community has remained  
2 proud and empowered. At Bright Star, we believe that we  
3 build that power through partnerships. Now, we're  
4 encouraged by UChicago Medicine's partnership to meet our  
5 needs by increasing access to the care we deserve and the  
6 public demand.

7           The plan goes way beyond trauma, because the  
8 needs in our community go way beyond trauma. The plan  
9 includes access to world-class cancer and specialty care.  
10 You've heard from the experts. Cancer is killing  
11 African-Americans, and on the South Side, there are very  
12 few options for the complicated cancer care our community  
13 so desperately needs. So where are we to turn when the  
14 University of Chicago is full, and our moms and our sons,  
15 daughters, siblings, get the dreaded news that they've  
16 got cancer?

17           The plan includes an emergency department the  
18 South Side can rely on. You've heard from doctors:  
19 Thousands of patients are arriving at the ED every year,  
20 only to leave without even seeing a doctor because there  
21 is not a single available bed, and the thought of waiting  
22 hour after hour for care is too daunting.

23           Our community has partnered with the University  
24 of Chicago to develop this plan. Please vote yes on Get

1 CARE.

2 Thank you.

3 CHAIRWOMAN OLSON: Is there anyone else that's  
4 signed in that has not spoken?

5 Okay. Seeing none, we'll move on.

6 Items approved by the Chairwoman.

7 MR. CONSTANTINO: Thank you, Madam Chairwoman.

8 There are three items approved by the Chair:  
9 Permit Renewal 13-011, Presence St. Joseph Hospital;  
10 Project No. 16-013, Little Company of Mary Medical Office  
11 Building; and Project No. 16-016, DaVita Jerseyville  
12 Dialysis.

13 Thank you, Madam Chairwoman.

14 CHAIRWOMAN OLSON: Thank you, Mike.

15 Items for State Board Action.

16 There are no permit renewal requests. There is  
17 no extension request. There is no exemption request.

18 We do have one alteration request, Project  
19 D-01 -- or D-01, Project No. 14-006, Northwestern Lake  
20 Forest Hospital.

21 May I have a motion to approve an alteration  
22 for Project 14-006, Northwestern Lake Forest Hospital, to  
23 increase the overall cost by 1.8 percent?

24 MEMBER GALASSIE: So move.

1 MEMBER GREIMAN: Second.

2 CHAIRWOMAN OLSON: I have a motion and a  
3 second. The Applicant will be sworn in.

4 (One witness sworn.)

5 CHAIRWOMAN OLSON: Mr. Constantino, your  
6 report, please?

7 MR. CONSTANTINO: Thank you, Madam Chair.

8 The permit owners are requesting a second  
9 alteration for Permit No. 14-006, Northwestern Lake  
10 Forest Hospital.

11 This project was approved by the Board as a  
12 replacement hospital in June of 2014 for 198 beds at a  
13 permit amount of approximately 378 million dollars.

14 The first alteration was approved by the Chair  
15 in April 2015, which increased the costs by 12.4 million  
16 dollars, or three percent of the original permit amount,  
17 and increased gross square footage by 16,100 gross square  
18 foot, or 3.3 percent.

19 The increase in this cost was due to a change  
20 in the permit holder's capitalization policy, and the  
21 increase in the gross square footage was due to the  
22 inadequate size, materials management, the mechanical  
23 systems, and central stairwell supply.

24 The second alteration is asking you for

1 approval to increase the cost to 397.6 million dollars,  
2 or 7.2 million, due to construction cost escalation, IDPH  
3 requirements, and unsuitable soil for building.

4 Thank you, Madam Chair.

5 CHAIRWOMAN OLSON: And the project had no --  
6 there was no negative findings on the request?

7 MR. CONSTANTINO: Oh, no; no negative findings.

8 MS. ORTH: Good morning. I'm Bridget Orth,  
9 Director of Regulatory Planning for Northwestern  
10 Medicine.

11 With me today are Matt Flynn, CFO of  
12 Northwestern Lake Forest Hospital, and Ron Powers,  
13 Director of Planning and Construction for Northwestern  
14 Medicine.

15 One year ago, we received approval for an  
16 alteration in our plant to increase the square footage  
17 for our replacement facility project in Lake Forest by  
18 approximately 16,000 square feet. At that time, we  
19 believed that the project contingency could absorb the  
20 7.2 million dollar cost associated with that increase,  
21 and so we did not request an increase in the construction  
22 costs at that time. However, in the year since that  
23 time, the continued high escalation rate in the Chicago  
24 region, coupled with an inordinate amount of unforeseen

1 conditions, has increased the contingency level to a  
2 level that may be inadequate to complete the project.

3           Northwestern Medicine has a proven history of  
4 delivering projects on time and on budget. Based on our  
5 extensive experience with major construction projects in  
6 the last decade, we know how important it is to maintain  
7 adequate contingency. Inadequate contingency levels lead  
8 to short-sighted decisions that can affect care delivery  
9 for years to come.

10           At this point, we believe that we have  
11 encountered all of the major unknowns, and we are  
12 confident that the approval of the additional funds  
13 requested today will be sufficient to ensure the  
14 integrity of the project and a successful execution and  
15 activation of this replacement facility that will improve  
16 access and care to the residents of Lake County and  
17 surrounding areas.

18           We are pleased to have received a positive  
19 state staff report and welcome any questions the Board  
20 may have.

21           CHAIRWOMAN OLSON: Thank you.

22           Any questions from Board members?

23           Seeing none, I would ask for a roll call vote.

24           MR. ROATE: Thank you, Madam Chair.

1 Motion made by Mr. Galassie, seconded by  
2 Justice Greiman.

3 Senator Burzynski?

4 MEMBER BURZYNSKI: I vote aye, as the project  
5 seems to be in conformance with the criterion of a  
6 reasonable municipal project.

7 MR. ROATE: Senator Demuzio?

8 MEMBER DEMUZIO: Yes, due to the fact that the  
9 Board has created -- or has indicated it's in conformance  
10 with the criterion.

11 MR. ROATE: Thank you.

12 Mr. Galassie?

13 MEMBER GALASSIE: I'll vote aye based on  
14 previous comments.

15 MR. ROATE: Thank you.

16 Justice Greiman?

17 MEMBER GREIMAN: I vote aye based on previous  
18 comments, also.

19 MR. ROATE: Thank you.

20 Mr. Hayes?

21 VICE CHAIRMAN HAYES: I vote aye, based on the  
22 favorable State agency report.

23 MR. ROATE: Thank you.

24 Mr. Johnson.

1 MEMBER JOHNSON: Yes, for the favorable report  
2 and previously stated comments.

3 MR. ROATE: Thank you.

4 Mr. McGlasson.

5 MEMBER MCGLASSON: Yes, for the previously  
6 stated comments.

7 MR. ROATE: Mr. Sewell.

8 MEMBER SEWELL: Yes, based on the previous  
9 comments.

10 MR. ROATE: Madam Chair.

11 CHAIRWOMAN OLSON: I vote yes as well for  
12 previous comments.

13 MR. ROATE: Nine votes in the affirmative.

14 CHAIRWOMAN OLSON: The motion passes. Thank  
15 you.

16 Declaratory rulings, there are none.

17 Health Care Worker Self-Referral Act, there are  
18 none.

19 Status reports on conditional/contingent  
20 permits, there are none.

21 At this point, we'll break for lunch. We will  
22 be back in 45 minutes, so at 1:15 we will reconvene.

23 Thank you.

24 (Meeting adjourned for the lunch break at

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12:30 p.m. and reconvened at 1:19 p.m.)  
CHAIRWOMAN OLSON: Okay. We're back in  
session.

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CHAIRWOMAN OLSON: The next order of business is applications subsequent to initial review.

The first project is H-01, Project No. 15-056, Transitional Care of Lisle.

The Applicant can come to the table, and Juan's going to make a couple comments.

MR. MORADO: I just want to make a few comments before we get started.

The next three projects are for long-term care facilities located in Health Service Area 7-C.

According to our Rules, Section 1130.620 that deal with the review procedures for this Board, I want to read a pertinent rule to you right now.

Each application will be reviewed and considered on an individual basis unless the Health Facilities and Services Review Board can establish and review criteria or procedures that pertain to or relate to comparative review or "batching" of applications.

We do not have such rules. Therefore, you're to consider the next few projects on their own merits. Please consider the applications and the results, their opposition, as well as the support letters, the testimony that will be heard today, but when you are asking your

1 questions and taking your vote, please be cognizant of  
2 the fact that it should be solely restricted to that  
3 particular project.

4 And I'd like to make the same comments to the  
5 Applicants who have the two successive applications  
6 coming up. Please keep your comments focused on the  
7 project that is up at this time.

8 In this particular planning area, we'll  
9 probably hear from the Applicants and others that there  
10 is current need of 138 beds.

11 So I just wanted to make those comments at the  
12 outset before we get going.

13 MEMBER GREIMAN: Do we have the right to change  
14 that rule now?

15 MR. MORADO: Unfortunately not, Judge.

16 Thank you.

17 CHAIRWOMAN OLSON: Okay. May I have a motion  
18 to approve Project 15-056, Transitional Care of Lisle to  
19 establish a 68-bed long-term care facility?

20 MEMBER DEMUZIO: So move.

21 MEMBER GALASSIE: Second.

22 CHAIRWOMAN OLSON: The Applicants will be sworn  
23 in, please?

24 (Four witnesses sworn.)

1 Mr. Constantino, your report, please.

2 MR. CONSTANTINO: Thank you, Madam Chairwoman.

3 We received a comment on the State Board staff  
4 report that I had put in front of you today. I don't  
5 know if you want to take a couple minutes and look at it.  
6 It's been e-mailed to you last week and it's been sent to  
7 the Applicants.

8 MR. MORADO: Were those comments timely?

9 MR. CONSTANTINO: It was timely, yes. 15-056  
10 is the project.

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

13 MR. CONSTANTINO: I'd like to make a couple  
14 comments about the -- comments on the State Board Staff  
15 we received.

16 The first comment I'd like to make, that  
17 comment states we have mistakenly took the number of  
18 individuals registered at the public hearing that was  
19 held in that project. That's correct. I didn't state we  
20 would take those individuals as the number of registered  
21 and who were there at the public hearing at that time.  
22 That was not the case. We estimated about ten  
23 individuals were at that public hearing.

24 The second comment I'd like to make is about

1 the lack of the information on the website. We make  
2 every attempt to put all of the information we receive,  
3 no matter who it's from, on that website. There's times  
4 we don't get it done, but that doesn't prevent anyone  
5 from contacting any of the staff -- Courtney, Juan or  
6 Jeannie -- and we'll get you that information without a  
7 FOIA request and you'll have it the same day.

8 We didn't -- we're very conscientious of trying  
9 to get everyone all of the information that we receive  
10 for the State Board.

11 CHAIRWOMAN OLSON: Thank you, Mike. We  
12 appreciate your diligence in that matter.

13 Okay. Your report.

14 MR. CONSTANTINO: The Applicant's proposing the  
15 establishment of a 68-bed long-term care facility in  
16 Lisle, Illinois, at a cost of approximately 15.8 million  
17 dollars, with an approximate completion date of December  
18 31st, 2018.

19 There was a public hearing on this project, and  
20 letters of support in opposition were received by the  
21 State Board Staff.

22 The Applicants do not meet a few of the State  
23 Board criteria, which included service access,  
24 unnecessary duplication, availability of funds, financial

1 viability, and reasonableness of costs.

2 Thank you, Madam Chairwoman.

3 CHAIRWOMAN OLSON: Thank you.

4 Comments for the Board?

5 MR. SHEETS: Good afternoon. My name is Chuck  
6 Sheets. I'm the attorney for the Applicant. I have to  
7 my left, Mr. Brad Haber and Mr. Brian Cloch, who are  
8 managing partners for the proposed facility, and on their  
9 left is Anne Cooper from my office, also.

10 Before I hand this over to Mr. Haber to begin  
11 the presentation, I just would like to make one comment.

12 I concur with Mr. Constantino that most of the  
13 information was promptly put on the website, but I would  
14 also point out that I don't believe that there is a rule  
15 that requires that information be put on the website.

16 With that, I give that to Mr. Cloch.

17 MR. CLOCH: Good afternoon. My name is Brian  
18 Cloch, B-R-I-A-N, C-L-O-C-H. I'm one of the principals  
19 and cofounders of Innovative Health.

20 I'd first like to thank the Staff for preparing  
21 such a thorough report and for the opportunity to respond  
22 to it.

23 Thank you also to the Board. We appreciate the  
24 time it takes to do the prep for these meetings and being

1 here today. Thank you for lending your expertise, taking  
2 the time to rediscover the merits of stand-alone,  
3 purpose-built, short-term transitional care and  
4 volunteering your time to help transform the health care  
5 delivery system in the State of Illinois.

6 Before we go into the details about the  
7 project, my partner in Innovative Health, Brad Haber,  
8 will address some of the financial concerns highlighted  
9 in the staff report.

10 MR. HABER: Thank you, Brian.

11 As mentioned, my name is Brad Haber, B-R-A-D,  
12 H-A-B-E-R, and I am also a principal and cofounder of  
13 Innovative Health.

14 I would also like to thank the Board and  
15 Mr. Constantino for preparing such a thoughtful and  
16 detailed report regarding Transitional Care of Lisle.

17 Realizing the Board has extensive experience  
18 within health care and financial reporting, I've  
19 attempted to address all the financial concerns raised in  
20 the staff report in the most efficient manner as  
21 possible.

22 With regard to availability of funds, the  
23 reasoning behind the staff report as it relates to the  
24 negative findings is due to the fact that we did not

1 provide a firm commitment from a financial institution  
2 with a hundred percent assurances the project will be  
3 financed.

4 As the former head of credit and underwriting  
5 for GE Capital's health care finance division from 2002  
6 to 2013, I can attest that at this stage of the  
7 development process, a true, no-outs commitment from any  
8 financial institution does not exist in the market today.  
9 In fact, a critical part of finalizing any financial  
10 commitment is being awarded the CON for the project.

11 I've been involved in over 12 billion dollars  
12 of transactions on both the debt and equity side of the  
13 business and am very comfortable with our ability to  
14 consummate this transaction.

15 With that being said, the capital stack is  
16 bifurcated into both debt and equity. From the equity  
17 side of the business, over the past six months, there has  
18 been requests for an extensive amount of information  
19 regarding our capital sources. We have supplied all the  
20 information that has been requested, and all indications  
21 are that we have met that requirement. We are fully  
22 prepared and have the capital available to move forward  
23 on this project and many more, should the Board give us  
24 the go-ahead today.

1           One of our equity partners, Justin Schuler,  
2           from OnPointe Health Development is here today to show  
3           his support for the transaction.

4           I am hopeful we have provided sufficient  
5           information to demonstrate the availability of our  
6           capital, but should you have any additional questions, I  
7           am sure Justin would be more than happy to elaborate on  
8           his firm's abilities to finance Transitional Care of  
9           Lisle.

10           Coming from a financing background and with the  
11           Board's requirements in mind, I have been diligent in  
12           making sure we have pursued the most cost-effective  
13           financing available in today's market.

14           In addition, I have been focused on making sure  
15           that we abide to the strictest set of standards.

16           In addition here today sitting next to Justin  
17           is Brad Wilson, who is the landowner in Lisle and who we  
18           are currently under contract with for sale of that site.

19           I am confident in the financial viability of  
20           this project. The State Board has a set of financial  
21           viability ratios that are extremely relevant within the  
22           overall health care sector but not specific to subsets of  
23           the industry, including skilled nursing.

24           Financial ratios that are most relevant to the

1 skilled nursing sector are percentage of debt to total  
2 capitalization and debt service coverage, with debt  
3 service coverage being the most critical, as it  
4 demonstrates the organization's operating efficiency and  
5 ability to meet current debt obligations.

6 The Board has set 1.5 times debt service  
7 coverage as a standard, and from my experience, that is  
8 spot-on accurate. Our Lisle project not only meets that  
9 standard, but doubles it at three times.

10 In terms of total capitalization, the Board has  
11 set a less than 50 percent standard, which is applicable  
12 to the health care field as a whole. When you separate  
13 out the skilled nursing, the standard within the industry  
14 is a target of less than 80 percent from conventional  
15 lending institutions and less than 90 percent for life.

16 The staff report notes that we are below that  
17 level in our first stabilized year, which is well within  
18 market standard guidelines and also meets the most  
19 stringent of underwriting criteria.

20 I would like to note that the Board staff  
21 report indicates the proposed project meets the  
22 requirements for the reasonableness of financing, as well  
23 as the terms of the debt financing criteria.

24 Days cash-on-hand is a ratio that is not

1 analyzed within the skilled nursing sector, but rather a  
2 ratio that is very critical when discussing hospital  
3 operations. From the perspective of a hospital,  
4 something in the neighborhood north of 180 days  
5 cash-on-hand is an ideal target. The Board standard for  
6 days cash-on-hand is set at greater than 45 days. Our  
7 project is essentially at that target level with 44 days  
8 in year three.

9 Of all the viability ratios, cushion ratio is  
10 not particularly relevant to skilled nursing. I can say  
11 that in my experience as a lender for the better part of  
12 my career, I have never asked, seen, or had any  
13 conversation that revolves around a cushion ratio.

14 It is also important to note we are not aware  
15 of any financial lending platform in today's market that  
16 utilizes cushion ratio as part of the underwriting and  
17 approval standards.

18 With that being said, from a financial  
19 viability and statistical review, Transitional Care of  
20 Lisle would meet all their criteria that active lenders  
21 and equity investors would look for when evaluating  
22 potential opportunities.

23 Lastly, with regard to reasonableness of  
24 project costs, due to the innovative nature of the

1 proposed project and the level of care that we're  
2 providing, the costs for removable equipment was exceeded  
3 by approximately \$7,000 a bed, which is less than  
4 \$500,000 in total.

5 State-of-the-art rehabilitation centers such  
6 Transitional Care of Lisle that provide therapy of this  
7 nature, require the best available equipment, which comes  
8 at a cost. These costs are further highlighted because  
9 Transitional Care of Lisle is a smaller 68-bed community.

10 Please note in our proposed operating model,  
11 and in contrast to a typical custodial community, such as  
12 Winchester House that we operate in Libertyville, there  
13 is no correlation between the cost of our equipment  
14 provided for our guests' wellbeing and the rate we are  
15 paid.

16 In other words, these additional expenses are  
17 incurred entirely by the property owners, and there is no  
18 additional financial burden placed on the payer.

19 Having a pure focus on the bottom line and not  
20 the guest's care is a shortsighted view and one that is  
21 contrary to the transformational change in health care.

22 I hope the Board takes comfort in the fact that  
23 the additional dollars spent are solely dedicated to the  
24 patient's experience, wellbeing, and ultimate timely and

1 successful recovery, all of which my partner, Brian  
2 Cloch, will expand upon next.

3 MR. CLOCH: Thanks, Brad. If this is isn't  
4 loud enough, just tell me and I'll pull away.

5 Okay. First of all, I want to thank you in  
6 advance for giving this project due consideration and  
7 recognizing upfront that much like Transitional Care of  
8 Arlington Heights' project this Board approved in 2011,  
9 Transitional Care of Lisle is a square peg in a round  
10 hole scenario that needs to be understood not from the  
11 standard merits but also the special merits of this type  
12 of innovation that stems from the current health care  
13 system.

14 I want to commend the Board for seeing beyond  
15 the opposition's argument and the perseverance of the  
16 status quo and for having a vision of the future of  
17 post-acute care and a new innovative model of health care  
18 delivery.

19 As you are probably aware, transitional care is  
20 a successful model of care that is happening around the  
21 country. It addresses the longstanding, untapped needs  
22 to perform short-term rehabilitative care.

23 It also addresses the fact that the hospital  
24 average length of stays decreased for those over the age

1 of 65 from 10.7 days in 1980 to 5.5 currently. Patients  
2 are being discharged sicker and quicker, and demand for  
3 post-acute rehab that can be provided at a lower cost and  
4 a higher quality continues to grow.

5 Like the promotion of assisted living 25 years  
6 ago, stand-alone transitional care is the next natural  
7 evolution in maintaining costs and delivering better  
8 outcomes.

9 Since we met last, Illinois' first  
10 purpose-built transitional care facility has opened its  
11 doors. Transitional care is now a reality. True to what  
12 we promised at the CON meeting back in 2011, the results  
13 in terms of reduced length of stay, improved  
14 return-to-home ratios, enhanced patient and family  
15 satisfaction, and reduced 30-day re-hospitalizations are  
16 outstanding.

17 At Transitional Care of Arlington Heights, our  
18 length of stay average is 15 days, compared to length of  
19 stays that exceed two and three years in skilled nursing  
20 centers, and 15 days, compared to the average length of  
21 stay of 32 days, 24 days, and 25 days, among the three  
22 short-term facilities that are located within a  
23 ten-minute travel time of the Lisle site.

24 Clearly, we are decreasing overall costs and

1 transitioning the people home, our guests home more  
2 quickly.

3 Our return-to-home ratio is at 97 percent.  
4 That's remarkable. Our guests are happy, as evidenced by  
5 the fact that several have made the trip down here today  
6 to support us and the very high post-discharge  
7 satisfaction results gathered by an independent agent.

8 We utilized a third party company to gather  
9 information on our guests' experience. The satisfaction  
10 rating for transitional care to date scored 100 percent  
11 versus 84 for the national average.

12 Family member response as far as satisfaction  
13 is also at 100 percent versus 82.3 for the national  
14 average, and our 30-day hospital readmission rate is 9  
15 percent, compared to the 19, 17 and 22, amongst those  
16 three facilities that are within a ten-minute time of our  
17 proposed Lisle site. Again, a remarkable improvement.

18 We expect some more results from Lisle.

19 So let me tell you a little more about the  
20 Transitional Care Center of Lisle. The project,  
21 Transitional Care of Lisle, is not another nursing home.  
22 Our goal is not to build another nursing home. Rather,  
23 our objective is to continue to reinvent the post-acute  
24 care experience with purpose-built, customer-centric,

1 high-acuity, short-term rehab care.

2 I'm sure that either you or a friend or a  
3 relative has needed this level of care at some point in  
4 time. While some people are satisfied with the  
5 traditional post-acute experience, many -- particularly  
6 those of my generation -- have a story to tell about the  
7 displeasure with the current system.

8 I personally have many friends who've called me  
9 looking for an alternative. We all know for many of us  
10 the options are simply not optimal. I'm delighted to  
11 have an alternative where I can confidently refer friends  
12 to Arlington Heights. I hope to have one in Lisle.

13 Like Arlington Heights, the Lisle recovery  
14 center will embrace the distance between illness and  
15 recovery and provide a healthy balance of the finest new  
16 facilities, treatment protocols, and highly skilled care,  
17 along with comfort and convenience in a non-institutional  
18 alternative setting.

19 At Transitional Care of Lisle Post-Acute Care  
20 Center, we'll offer a dedicated focus on post-acute  
21 rehab, a nurse-to-guest ratio of one-to-ten versus  
22 traditional staff, one-to-25 or one-to-30; primarily  
23 private rooms with private baths and homelike  
24 furnishings, comfortable accommodations for guests and

1 signature hotel-like amenities; multiple restaurant-style  
2 dining options that feature fine cuisine and selection,  
3 thoughtful conveniences that minimize the disruption and  
4 offer privacy.

5 But beyond the benefits that a brand new  
6 purpose-built center offers, there's also a cultural  
7 shift and plan that is critical to the successful  
8 outcomes I just described.

9 Our transitional care centers offer rehab  
10 services within hours of admission; therapy seven days a  
11 week to maximize progress and minimize regression over  
12 the weekend; targeted discharge dates are posted in each  
13 suite upon admission because it's good to have a goal  
14 that you're reminded of regularly; engaging events like  
15 wheelchair volleyball and comedy night to get people up  
16 and out and motivated.

17 Even meals become an extension of the therapy  
18 programs; stereotypical tray services gone and dinner out  
19 is a part of our guest recovery plan.

20 Specialty drafted critical pathways address  
21 high rehab and complex securities. Higher staffing  
22 ratios mean more quality time with each guest.  
23 Electronic health records provide convenience and  
24 efficiency. Onsite physicians offer daily oversight by a

1 physician or a nurse practitioner.

2 It's also important to know that this high  
3 level of service and convenience is available at the same  
4 daily costs to the health care system. The revenue model  
5 doesn't change, just the length of stay, therefor saving  
6 the overall health care system resources.

7 As you can see, Transitional Care of Lisle will  
8 address specific underserved need, well beyond more beds  
9 and a new building.

10 Transitional Care offers a welcome, innovative  
11 alternative, while helping control costs and minimize the  
12 use of higher costs of alternative settings that are not  
13 medically necessary.

14 There are several reasons why this project  
15 should be approved. First, let's talk about need.

16 As the report states, there's a projected  
17 138-bed need for the 7-C planning area. The Board's goal  
18 is to have the foresight to book it today with a plan for  
19 the future.

20 It's presented by Staff the growth rate among  
21 65- to 74-year-olds was projected at 33 percent. That's  
22 at six percent compounded annually, which is 23,300  
23 people.

24 The growth rate among 75 plus is projected at

1 16 percent, or 8,300 people.

2 The age rate is happening. The need has been  
3 clearly documented and now it's the Board's unfortunate  
4 decision of being able to correctly manage for it with an  
5 innovative new care delivery model.

6 If we act now, we can be better prepared at the  
7 time the center opens in the projected two and a half  
8 years.

9 Need is further underscored by the fact that  
10 the Board Report indicated the majority of facilities  
11 within a reasonable drive time goes from a nonadjustable  
12 occupancy of 85 percent or higher. Of course, some of  
13 the traditional nursing homes in the area, all with low  
14 targeted occupancy, is reflected by the measured  
15 licensed, not functional beds. It's an important  
16 question to ask, why is this the case?

17 First of all, many of these licensed beds are  
18 not full because they're not in service. The state's  
19 occupancy calculations are based on licensed beds, not  
20 actual operating beds. Many of those licensed beds have  
21 been taken out of service because consumers like you and  
22 I don't want a roommate or two roommates in the same  
23 double or triple occupancy room with us when we are sick  
24 and trying to recover. We want privacy. These beds

1 can't be occupied if they don't exist. They've been  
2 taken out of circulation because consumers don't want  
3 them.

4 The staff artificially lowers the occupancy  
5 rate, which actually reduces operating versus truly  
6 functional methods. Many of these facilities are fully  
7 or near fully occupied.

8 Secondly, communities with low occupancy rates  
9 have had a low quality rating. In fact, 26 facilities  
10 listed on the staff report on Table 11 have a utilization  
11 of 80 percent lower, or one-third of the CMS rating of  
12 two stars or below. A cause and effect relationship  
13 could be applied.

14 Lastly, the opposition points out that their  
15 interpretation of a need is with the underserved, less  
16 affluent population that is currently not served by the  
17 existing local nursing homes.

18 If our opposition is correct, Transitional Care  
19 of Lisle will yield to the community and we do intend to  
20 accept Medicaid recipients for part of the  
21 Medicare/Medicaid Alignment Initiative to improve quality  
22 and decrease costs.

23 Incidentally, we're also working with other  
24 entities to improve quality, reduce the admission, and

1 decrease costs.

2 Beyond the definition of need as being defined  
3 as bed need, there's another need, the need for  
4 transformational change in the way health care is  
5 delivered.

6 Health care is changing, the role of acute  
7 care. Stay is being redefined. Population is changing.  
8 Their needs are changing and their expectations have  
9 evolved. It is clearly time for the health care delivery  
10 system to evolve as well.

11 Beyond the stated bed count, the true need for  
12 innovative customer-centric, short-term stay and  
13 high-acuity option that will raise the bar for post-acute  
14 is very apparent.

15 In the matter of duplication of services, there  
16 is no comparable duplication of services because no  
17 one -- no area provider offers stand-alone,  
18 purpose-built, specialized short-term care.

19 Rather, the existing traditional nursing homes  
20 provide an institutional model of custodial care that is  
21 supplemented with a small rehab unit. We are very  
22 familiar with this model. It is exactly what we operate  
23 on behalf of Lake County Board in Libertyville.

24 There is a distinct difference in the look and

1 feel in the way care is delivered between Transitional  
2 Care of Arlington Heights and our current Lake County  
3 project.

4 I can safely and confidently tell you that  
5 while the opposition is afraid of competition, the  
6 experience provided in these two completely different  
7 settings does not compare.

8 The overwhelming majority of these nursing  
9 homes are providing care for an older, over-85  
10 population. Transitional Care of Lisle will provide for  
11 a broader range of patients. Average age has been in the  
12 mid 70s. They're increasingly being discharged sooner  
13 and with higher acuity from the hospital.

14 The only welcome alternative to traditional  
15 nursing home environments is home care. As a home care  
16 company owner, I know in many of these cases a home care  
17 solution is not the best option. There are many people  
18 who choose to go home that could benefit from an  
19 inpatient short-term rehab who refuse to go to a  
20 traditional nursing home. This subsector is a whole new  
21 market that the traditional nursing home does not serve.  
22 These people would experience better options, including  
23 lower readmission rates if they came to transitional care  
24 prior to going home.

1           In our experience, this new scenario is  
2 actually coming to fruition and it represents  
3 approximately 25 percent of the population we serve today  
4 in Arlington Heights. There is no duplication of  
5 services, and that is an apples-to-orange comparison.

6           Transitional Care of Lisle will meet the needs  
7 that are not currently being met by existing nursing  
8 homes and for people with secure needs that are too  
9 complex, who do not prefer to go home with just home  
10 health, people like Mark's wife, Caryn, who he spoke  
11 about earlier, who were so motivated to not choose a  
12 traditional skilled nursing option, they paid  
13 out-of-pocket for care and services; people like Mark  
14 Keller, age 57, who was discharged from the hospital with  
15 pneumonia, dependence on oxygen, Hodgkin's lymphoma,  
16 hypothyroidism, atrial fib, and was deconditioned. Home  
17 health care couldn't effectively meet his needs, and the  
18 nursing home care wasn't a choice for what was agreeable  
19 to this young man. He rehabbed with us until he was  
20 increased in stamina and able to be discharged following  
21 his rehab care and was ready to sustain a successful  
22 surgery for esophageal reconstruction; people with those  
23 who provided letters of support for the transitional care  
24 concept who don't want to share a room, walk down the

1 hall to use the bathroom, eat institutional food, if they  
2 should, God forbid, fall and break their hip or need  
3 rehab; people like area health care professionals,  
4 doctors, nurses, therapists, geriatric care managers,  
5 health care professionals like Jeff Schmidt, who engage  
6 medical groups and represents over 500,000 patients; and  
7 Randy Fike, who manages risk for Blue Cross Blue Shield  
8 matters, both of whom joined us today to support the  
9 transitional care model because they know there ought to  
10 be a better way.

11 When all this is taken into consideration, it  
12 is clear that a transitional care model targets the  
13 underserved market, as such existing facilities do not  
14 serve, meet the needs of this intended market -- I'm  
15 sorry -- as such, existing facilities do not serve or  
16 meet the needs of this intended market.

17 And, finally, most importantly, in my opinion,  
18 let's talk about quality. A vote for transitional care  
19 is a vote for quality.

20 Table 11 of the staff report highlights 62  
21 facilities within a 30-minute adjusted travel time radius  
22 of Transitional Care of Lisle, over half of them with CMS  
23 star rating of three stars or below. About a third were  
24 two stars or below. It appears there's ample opportunity

1 to raise a quality mark.

2 Transitional Care's specialized focus will  
3 enhance outcomes and patient experiences, like so many of  
4 the guests that came to support us today.

5 Transitional Care of Lisle will coordinate with  
6 the area physicians and hospitals to offer critical care  
7 pathways that address high rehab and complex care needs,  
8 including, but not limited to, cardiac care, ortho, and  
9 wound care; and lastly, multiple sights that show healing  
10 design that -- like that which Transitional Care offers  
11 can improve a patient's outlook on care, increase patient  
12 satisfaction, and ultimately help support a client's  
13 journey toward recovery.

14 It's important to note that this high level of  
15 care of service and convenience is available at the same  
16 costs to the health care system. Revenue model does not  
17 change; only length of stay due to more intensive therapy  
18 and care, thereby reducing overall costs.

19 In summary, all the reforms changed are on more  
20 shorter acute-care lengths of stay, and an increase in  
21 outpatient procedures will continue to result in  
22 discharging people from the hospital sicker and quicker,  
23 thereby driving an increased need for high-quality,  
24 short-term, high-acuity, post-acute care.

1           There is a stated and documented published need  
2           for 138 beds in this planning area. Furthermore, there  
3           is a desire on both the part of the consumers and health  
4           care community to bring a new choice to the marketplace.

5           There is not really -- this is not really a  
6           conversation about duplication or maldistribution. It is  
7           truly and simply a conversation about status quo and  
8           innovation.

9           At a time when money is scarce, costs are  
10          soaring, and our nation is aging, we need to explore  
11          cost-effective, customer-centric, innovative alternatives  
12          to the health care's current status quo.

13          Transitional Care of Lisle offers choice, it  
14          offers quality, it offers cost savings. Transitional  
15          care is a model of the future. Our opposition may fear  
16          it, but hospitals know it, doctors know it, insurers know  
17          it, and the patients want it.

18          Please vote in favor of bringing innovation to  
19          Lisle.

20          Thank you.

21          CHAIRWOMAN OLSON: Thank you.

22          Questions from Board Members? Doctor?

23          EX OFFICIO MEMBER GOYAL: Thank you very  
24          kindly. I do not vote on this Board, but I can ask

1 questions, if you'd be so kind to help me understand.

2 So I have two questions: One, is the care in  
3 the transitional care facility paid by Medicare on a DRG  
4 basis?

5 MR. CLOCH: It's paid by -- the Medicare is a  
6 DRG basis, yes.

7 EX OFFICIO MEMBER GOYAL: So the second  
8 question, then, is, as hospitals are paid on DRG now?

9 MR. CLOCH: Well, I'll answer it this way.  
10 It's not DRG, it's PPS. It's a different system but the  
11 same --

12 EX OFFICIO MEMBER GOYAL: Similar. Similar,  
13 right. I understand that.

14 So hospitals are paid on a similar basis now,  
15 but they also now have a skin in the game in that if a  
16 patient stays too long, they still get the same money,  
17 unless it's an outlier. And, secondly, if a patient is  
18 readmitted, then obviously they're penalized.

19 Does transitional care have such skin in the  
20 game?

21 MR. CLOCH: Yeah. It's a great question and an  
22 evolving strategy.

23 So, currently, contrary to what you might  
24 think, it's actually advantageous financially for a

1 transitional care facility to increase length of stay.  
2 So we've been contrarian to the industry, which is why  
3 people don't like us, our opposition doesn't like us,  
4 because we have been managing length of stays at 15 days,  
5 where our competitors, as documented, might be at 20 or  
6 25.

7 So we've been participating in -- like Jeff  
8 Schmidt was here from DuPage. We're taking on risks for  
9 populations of people. The reason why they're excited  
10 about us is we're managing length of stay, where we --  
11 it's advantageous for us to increase length of stay, but  
12 we've been working on things to reduce it.

13 So the future is going to be value-based, what  
14 you're describing, and so we're working with value-based  
15 agencies, like, you know, whoever might want to join, or  
16 other payers to own the risk for these patients, and so  
17 they like us because we manage length of stay to a lower  
18 amount and we discharge home appropriately.

19 So -- I'm sorry it's a long answer.

20 EX OFFICIO MEMBER GOYAL: Thank you very  
21 kindly.

22 CHAIRWOMAN OLSON: Other questions?

23 VICE CHAIRMAN HAYES: Thank you, Madam  
24 Chairwoman.

1                   When will you be, you know, going ahead --  
2                   could you describe the application process for Medicare  
3                   and then for Medicaid, and will these be done  
4                   simultaneously?

5                   MR. SHEETS: I was expecting a financial  
6                   question. That's why I handed him the -- I handed him  
7                   the mic.

8                   Actually, it does occur simultaneously, so what  
9                   happens traditionally is it takes a little longer to get  
10                  certified for Medicare than it does Medicaid. So some  
11                  buildings will only seek Medicaid initially and Medicare  
12                  will grab that survey and use it for Medicare when the  
13                  time the paperwork is processed, but it does take quite a  
14                  bit of time to get certified in the SNF industry for  
15                  Medicaid and Medicare, anywhere from 90 to 180 days.

16                  VICE CHAIRMAN HAYES: So you're saying that a  
17                  lot of times they'll go forward with their Medicaid,  
18                  getting certified for that, because Medicare will use  
19                  that process and continue on for that.

20                  MR. SHEETS: Correct.

21                  VICE CHAIRMAN HAYES: Okay. And how long again  
22                  did you say it would take?

23                  MR. SHEETS: 90 to 180 days, depending on a lot  
24                  of different factors that are outside of our control.

1           There's an inspection of the building that  
2           takes place for Medicare and Medicaid, and then after the  
3           building passes, then a survey is ordered by the  
4           Department of Public Health's Regional Survey Team, and  
5           that's ordered and can take anywhere from 30 to 45 days,  
6           and once that's processed, you know, eventually you're  
7           accepted into Medicare and Medicaid.

8           VICE CHAIRMAN HAYES: Could you also, then, for  
9           the financial questions now, you know, basically, you  
10          describe here a leasing of what, the land there, or the  
11          leasing of the facility?

12          MR. HABER: So the land is owned. It's not  
13          leasing, but what happens is in a typical transaction  
14          like this is an opco and propco. The operations are  
15          separated out from the real estate, and in our particular  
16          instance, we have a safe ownership for both. So it's  
17          essentially right hand and left hand. We own the real  
18          estate for one entity and the operations of another. So  
19          it's a lease to ourselves.

20          VICE CHAIRMAN HAYES: And the land, you have  
21          not been able to close on that yet.

22          MR. HABER: The land we have under contract.  
23          We have the ability to, obviously, subject to approval  
24          here, but contrary to what was stated today, we do have

1 that land under contract and the ability to close on that  
2 at any time.

3 VICE CHAIRMAN HAYES: Okay. So the April 21st  
4 deadline had nothing to do -- that doesn't affect you.  
5 Basically, you're saying that that doesn't affect this  
6 April 21st deadline that was mentioned in the public  
7 participation.

8 MR. HABER: It does affect us financially, so  
9 we had to label 21st under the contract. We subsequently  
10 have -- we have the ability to extend it. That costs us  
11 some money to do. It's not fundable. It doesn't go  
12 towards the costs or towards our acquisition price, but  
13 we have the ability to extend.

14 VICE CHAIRMAN HAYES: Now, what about the loan,  
15 then? You have this with your PNC bank there, and then  
16 you have -- you know, basically there is no firm  
17 commitment per se.

18 Could you explain why that is not available? I  
19 mean, what you have here is somebody that says, well, we  
20 know you, but we still have to go through a lot of credit  
21 checks and our normal credit procedures.

22 MR. HABER: Sure. That's a great question.

23 My background is financing with GE Capital, so  
24 there's really two answers: One, affirming that you're

1 from a financial institution means if you go to them,  
2 they are approved and they're going to fund the  
3 transaction. So if they're giving you a firm commitment  
4 today, one without zoning, without a CON, it's  
5 problematic for them. It's just not available. They  
6 couldn't get approval to do that, mostly because if they  
7 did that and they came to them without that, they would  
8 be required to fund that.

9 The other issue is any financial institution --  
10 I can tell you from being effective -- if you give them a  
11 firm commitment, it has to be on the balance sheet as a  
12 liability. Most financial institutions do not want that  
13 as a liability at this stage of the game. There's just  
14 not enough information to give the lender at this point  
15 to give them a commitment. They can give you reasonable  
16 assurances, but a firm commitment doesn't exist. That's  
17 from a financial lender as well as --

18 MR. SHEETS: Let me add to that a little bit,  
19 because this has sort of the transformed over the years  
20 as we've been in front of you.

21 When we -- five, six years ago when we were  
22 going through a little bit of a financial crisis, we had  
23 a lot of nursing home projects that were up here that had  
24 commitments for financing and had problems with those

1 financing commitments. A lot of those were HUD related,  
2 if you recall, but believe it or not, over the last two  
3 years, we've had the opposite occurred. We now have  
4 funding everywhere for these projects, which we have  
5 private equity funding coming out of the woodwork, and  
6 HUD is actually being aggressive on new buildings, which  
7 they never even did until about two or three years ago.

8 So I think what we're seeing is a  
9 transformation a little bit on how these projects are  
10 financed.

11 We have an equity partner in this deal that is  
12 very well off, and we brought him with us, in case you  
13 have any questions, because we wanted to make sure that  
14 you understood that we're going to go forward with this  
15 project, if approved on the financing, no matter what.

16 MEMBER GALASSIE: Can I interrupt for a moment,  
17 just specific on this issue -- I apologize -- because I'd  
18 like to drill it down.

19 I respect that, Chuck, and I certainly respect  
20 your background and experience in this area, so accept  
21 any ignorance in that respect, if you will.

22 I'm still having difficulty understanding why  
23 that assurance that is represented here today from these  
24 individuals who I'm sure are highly credible wasn't

1 included in the package that was submitted. Because I  
2 have to tell you, despite your extensive experience in  
3 financing, which I do respect, we get numerous  
4 applications that have financing committed.

5 So while, I agree with you, it's a different  
6 era today with the banks, just help me get over that  
7 hurdle.

8 MR. SHEETS: Well, we did respond, and actually  
9 Mr. Constantino sent us a letter asking for a lot of  
10 different things relating to financing, and we did  
11 respond with several letters.

12 The letter that you have in front of you for  
13 financing on this project is an identical letter that one  
14 of the competitors uses that you will hear later and that  
15 you approved at the last meeting. It's not an unusual  
16 letter at all.

17 Basically, what they're saying is, we want to  
18 do this deal, but we're not going to do it until they go  
19 through all the due diligence and, as you know, just from  
20 the business community, they have to go through so many  
21 steps of approving a build of a piece of property on a  
22 piece of land. It's not only zoning, but obviously  
23 environmentalists have to be done. There's so many things  
24 that have to be done that a lending institution wants as

1 an exception before they'll give you a firm commitment  
2 that it's -- it's just too early in the game.

3 I suppose if we -- you know, if we had someone  
4 who's willing to throw up all the cash, then we could  
5 give you that but --

6 We've had projects that were smaller where  
7 that's been the case where we've had people with a bank  
8 account, just to put that up, but in this case, I think  
9 we've given you, you know, more than enough for you to  
10 rely on.

11 Anne, I don't know if you want to add to that.

12 MS. COOPER: In addition to the information  
13 that you have in your packet, we did send a letter to  
14 Mr. Morado from Jerry Williamson, who is one of the  
15 partners for OnPointe, indicating the net worth, and  
16 given that there was a lot of personal information, we  
17 requested that that information not be disclosed on the  
18 Board's website, and Mr. Morado, I believe he did review  
19 that letter that we sent to him?

20 MR. MORADO: Yes.

21 MEMBER GALASSIE: And thank you for letting me  
22 interrupt.

23 Can I just ask Mike to validate the comments  
24 just made for us?

1 MR. CONSTANTINO: Yeah. I've always had  
2 trouble with this, Dale.

3 Okay. I don't understand why individuals who  
4 have a good relationship with these lenders -- and these  
5 folks do, I'm sure; just like you, I'm sure they do --  
6 why they can't get a letter from them that says if  
7 this Board -- if the Board approves this project, we will  
8 provide financing for them.

9 That's all we're asking them to do.

10 MEMBER GALASSIE: It's the yin and the yang.

11 MR. CONSTANTINO: Yes.

12 And the other issue that Chuck mentions, the  
13 project he refers to, or the other Applicant, they have a  
14 history with this Board of providing financing for the  
15 projects. They have a long history. That's the Alden  
16 Group that Chuck was referencing with that other letter  
17 that he mentioned. That's the reason we accepted that  
18 letter, because they provided evidence that they can get  
19 the financing, even though they didn't provide us with a  
20 firm commitment.

21 MEMBER GALASSIE: Thank you, Madam Chair.

22 CHAIRWOMAN OLSON: John.

23 VICE CHAIRMAN HAYES: Finishing up now, what is  
24 the name of this equity investor then?

1 MS. COOPER: It's OnPointe Development, and  
2 Jerry Williamson is one of the principals of OnPointe  
3 Development.

4 VICE CHAIRMAN HAYES: Okay. And he owns the 51  
5 percent of that, is that correct?

6 MS. COOPER: Yes.

7 MR. SHEETS: He's sitting right behind us.

8 VICE CHAIRMAN HAYES: And what percentage of --  
9 your loan will cover what? 98 percent of the project or  
10 less?

11 MR. HABER: Yeah. The loan, generally you're  
12 talking about 80 percent. It looks a little bit skewed  
13 in the CON application. There are certain expenses that  
14 are not allowed; for example, land lease costs. I think  
15 we might have about 84 percent in there, which is still  
16 within the range. We're probably closer to somewhere  
17 between mid 70s when you factor in all of the true costs  
18 for the transaction.

19 VICE CHAIRMAN HAYES: So about 25 percent has  
20 to do with the equity component.

21 MR. HABER: Correct. Let's deal with that  
22 roughly five million dollars in equity, upwards of five.

23 VICE CHAIRMAN HAYES: Okay. Thank you.

24 CHAIRWOMAN OLSON: Do you have a question,

1 Judge?

2 MEMBER GREIMAN: I don't want to violate the  
3 Chairman's orders.

4 CHAIRWOMAN OLSON: Please don't.

5 MEMBER GREIMAN: I won't do that. But is my  
6 understanding correct that the same people own this  
7 project that own the next one? Is that right?

8 MR. SHEETS: That's correct, Judge.

9 MEMBER GREIMAN: So this is 16 minutes away.  
10 So Aurora is 16 minutes away.

11 MR. SHEETS: That's debatable. One's on one  
12 side of the area, the west side of the area, and the  
13 other's on the east side, but if you're familiar with the  
14 area, one's out by the mall.

15 MEMBER GREIMAN: It might not be 16, but it's  
16 close to 16. So 16 minutes and we're all in the same  
17 area and we have 68, so that's double, so double 68 these  
18 owners are asking us today.

19 MR. SHEETS: Correct, Judge, and the rule that  
20 Mr. Morado read earlier, the rule says that, you know,  
21 that --

22 CHAIRWOMAN OLSON: We're getting close to the  
23 line over there. We're getting very close to the line.

24 MR. SHEETS: Each particular project will be

1       judged separately based on the bed need that was in  
2       effect.

3               MR. MORADO: There's a 138 bed need currently  
4       in the area.

5               MEMBER GREIMAN: Yes, I understand.

6               CHAIRWOMAN OLSON: Any questions?

7               I actually have a couple questions. I want to  
8       just follow up.

9               Oh, I'm sorry. Go ahead.

10              MEMBER BURZYNSKI: Thank you.

11              I think you might have addressed this, but I'm  
12       not sure that I quite followed everything.

13              Can you again review with us the financial  
14       viability and how you responded to that finding? I'm not  
15       exactly sure that I understood how you dealt with that.

16              If my memory serves me, you said nobody can  
17       meet that, but I --

18              MR. HABER: Which particular ratio?

19              MR. SHEETS: I think he's talking about the  
20       cushion ratio because that's the one no one can meet.

21              MR. HABER: Yeah. The cushion ratio is one  
22       that is just -- it's used in the health care field; it's  
23       not used in skilled nursing.

24              The one I was referencing that was days cash on

1 hand, we're at 44 days. The requirement is 45 days. To  
2 put that in context, that's about \$20,000 in cash for  
3 that -- for that one day.

4 CHAIRWOMAN OLSON: I have just a couple  
5 questions.

6 To follow up with what John's talking about, I  
7 understand that you'll get your Medicaid certification  
8 before your Medicare certification, but when is it in the  
9 process that you plan to apply for both? Like five years  
10 after you're open, or five days after you're open,  
11 or what is that?

12 MR. SHEETS: Well, here's how it usually goes,  
13 Madam Chairman.

14 Before we can -- we fill out the Medicare 855  
15 Form, which is this long form -- it's not that long, but  
16 it's long enough -- that it gives all the information  
17 about the ownership and where the building's located.

18 You essentially fill out the 855 and then you  
19 submit it to Medicare, and Medicare has to review many  
20 different things in that application, and it takes a long  
21 time, but before they will actually act on the  
22 application, you have to be licensed. So we usually  
23 submit the form without the license and then we  
24 supplement the license in the hope that the intermediary

1 will look at it ahead of time.

2 It usually takes 90 days total for them to  
3 review that application and approve the owners. They run  
4 them through and it's a pretty substantial review.

5 CHAIRWOMAN OLSON: And then out of the 68 beds  
6 that you're asking for, do you have any idea how many --  
7 do you have put down on the Medicare/Medicaid application  
8 how many beds you want approved?

9 MR. SHEETS: You do. I think have to on  
10 Medicare, a hundred percent on Medicare. On Medicaid, I  
11 know it's based on the volume.

12 CHAIRWOMAN OLSON: How you can stay financially  
13 viable with it.

14 MR. CLOCH: The Medicaid -- you know, the focus  
15 of this facility is short-term transitional, so we're not  
16 doing custodial.

17 CHAIRWOMAN OLSON: I understand.

18 MR. CLOCH: So from that application, it's a  
19 matter of how much volume would we --

20 CHAIRWOMAN OLSON: Oh, I see.

21 MR. CLOCH: Like DuPage Medical Group was one  
22 of them, what does their membership look like? Will we  
23 be utilizing this building for their membership?

24 CHAIRWOMAN OLSON: And certainly DuPage -- it

1 will be based on the rules.

2 I do have another question, and I think, Mike,  
3 this is for you, but I want to just want to confirm and I  
4 think you alluded to this in the report.

5 When we look at these utilizations, and I think  
6 that Brian spoke to this, they're probably falsely low  
7 because some of the beds that are not -- while they're in  
8 their inventory, they're not usable. So that would make  
9 some of the numbers look falsely low.

10 MR. CONSTANTINO: That's correct.

11 CHAIRWOMAN OLSON: Which, and I believe I've  
12 said this before, is an issue that the nursing home  
13 industry has created for themselves.

14 So if they fix that issue, I don't know how  
15 this Board's -- you know, we have to go off what we're  
16 seeing, and I see that in this application under  
17 1125.580, it says there is no bed surplus in this HSA,  
18 and there's a 138 bed need, is that correct?

19 MR. CONSTANTINO: That's correct. That would  
20 be correct.

21 CHAIRWOMAN OLSON: And does somebody else have  
22 a question?

23 MEMBER MCGLASSON: Are you presently permitting  
24 Medicare/Medicaid patients?

1 MR. CLOCH: Dual eligibles; yes, sir.

2 MR. MORADO: How many beds are  
3 Medicare/Medicaid in this facility?

4 MR. CLOCH: I actually don't know of the  
5 Medicaid. Do you know?

6 MR. SHEETS: I think it's about 25 percent of  
7 them.

8 MR. CLOCH: I actually don't know.

9 MEMBER GALASSIE: Two? Ten? Thirty?

10 MR. CLOCH: I'm under oath and I don't want to  
11 say anything. I really don't know.

12 So the target that we're looking for is the  
13 population being short-term custodial care. So we  
14 participate -- we have contracts with -- we will have  
15 contracts with the two eligible ones. Medicaid has  
16 shifted 185,000 lives from Medicaid to an MMI program.  
17 So we participate in managing their members that need  
18 short-term rehab, so...

19 CHAIRWOMAN OLSON: So is it fair to say that  
20 the -- go ahead.

21 MR. SHEETS: Just to finish that question, the  
22 other thing to know is that even Medicaid, as you're  
23 aware, is going to managed care. So as we work with the  
24 different providers, you know, that are managing Medicaid

1 managed care -- whether that's Aetna or IlliniCare or  
2 whatever -- you know, they're going to send us Medicaid  
3 only patients that are in need of that short-term rehab.  
4 So yeah, there's no financial --

5 You know, we're using the NCO model will  
6 determine how many people will go in, so if they want to  
7 send us more patients, I'm sure Brian will take them.

8 MR. CLOCH: Yeah.

9 Two things. The shift in health care they're  
10 talking about is -- my words are, it's all shifting to  
11 value-based, like groups like DuPage Medical Group and  
12 Evista, and lots of other groups that are taking on  
13 their -- Advocate even -- they're taking on the risk for  
14 the ICP program, which is straight Medicaid people.  
15 They're looking for partners that I say downstream, who  
16 could do more for less than what they're paying higher  
17 costs, expensive alternatives. I'm sure the doctor  
18 probably can speak to that need.

19 You know, everybody's looking to manage  
20 population of people.

21 We want to be payer agnostic. We really don't  
22 care who the payer is. As long as they're willing to pay  
23 the services we provide, we're in.

24 So what I can do is provide a high level of

1 care for short-term rehab for a custodial Medicaid rate.  
2 That we won't do. So we have to find a way to do that.  
3 We don't do custodial.

4 Can I just speak to defend myself for one thing  
5 I've been answering?

6 While I've only presented one project here that  
7 was approved, ultimately, Transition Care of Arlington  
8 Heights, the project has been successfully financed and  
9 is open and is operating.

10 I also own another company and we've refinanced  
11 successfully 24 other assisted living and independent  
12 living facilities through HUD and other conventional  
13 lenders. So while I might not be Alden, I've done quite  
14 a few deals successfully myself, so...

15 CHAIRWOMAN OLSON: Other questions?

16 Yes.

17 MEMBER SEWELL: Could you continue with your --  
18 could you continue with your discussion -- that's what it  
19 is. I haven't talked about it.

20 Keep going with your discussion with these  
21 financial ratios. Assuming that we agree with you on  
22 cushion ratio and maybe even days cash on hand, what  
23 about the net margin percentage and current ratio? Could  
24 you say something about that?

1 MR. SHEETS: Yeah. So in terms of net margin  
2 of percentage, I did not address it because we've met the  
3 requirements. That was actually why. I'm not sure there  
4 was anything specific you wanted to know about it. I  
5 really --

6 MEMBER SEWELL: I really just wanted to cover  
7 each one of them.

8 MR. HABER: Yeah. So in terms of the  
9 requirements that we've met, I think I can ignore those.

10 So the net margin percentage; obviously, needs.  
11 Currently ratio, we've met, so we did not address that.  
12 So I didn't address that, but the debt control  
13 capitalization and that --

14 MEMBER SEWELL: You did address the debt  
15 control capitalization?

16 MR. HABER: That's the one where the value was  
17 85 percent for conventional financing and 90 percent for  
18 HUD. So we're under that requirement.

19 Just further direction, if you look at the  
20 total project cost, there's about two million dollars of  
21 costs that are not allocated or are not allowed to be put  
22 into CON, so we're probably closer to mid 70s when it's  
23 said and done. That's when we're about 25 percent equity  
24 or close to five million dollars total for the

1 transaction.

2 We've talked about the days cash on hand and  
3 the cushion.

4 MEMBER SEWELL: Okay.

5 CHAIRWOMAN OLSON: Other questions from Board  
6 Members?

7 MR. CONSTANTINO: Madam Chairwoman -- oh, I'm  
8 sorry.

9 CHAIRWOMAN OLSON: Go ahead, Mike.

10 MR. CONSTANTINO: I do want to make one comment  
11 about what Brian said.

12 It's true, they've been approved for one  
13 project that's been before the Board here and they got  
14 financing for it. That's all true. However, the  
15 Applicants were different, that's why I didn't consider  
16 that. Similar to what I did with Alden.

17 CHAIRWOMAN OLSON: Okay. Thank you.

18 VICE CHAIRMAN HAYES: One quick question I just  
19 want to make to clarify. On page -- and this has to do  
20 with the financial area and the Table 9 -- or it's right  
21 above Table 9, excuse me.

22 So, you know, basically, if you don't take,  
23 what do you call it, Medicare for longer term patients --  
24 or Medicaid -- you're not going to take Medicaid for

1 longer term patients, okay? So do you have any idea how  
2 many -- what percentage of Medicaid patients you would be  
3 working with?

4 MR. CLOCH: I honestly don't at this point. I  
5 can't even project. It really all depends on the  
6 upstream partners that we end up creating, like DuPage  
7 Medical Group and other people. We have to meet their  
8 membership. So it will --

9 Again, I'm not really concerned because we're  
10 payer agnostic. As long as we can get -- as long as the  
11 payer recognizes the services we provide, they're willing  
12 to pay for. Medicaid, Medicare, straight Medicaid, dual  
13 eligibles, we're good with any of that, as long as they  
14 recognize the value of what we're doing, so it's --

15 I don't have a firm commitment of what we're  
16 going to do right now. Every market's little bit  
17 different.

18 VICE CHAIRMAN HAYES: That's kind of vague that  
19 you're saying that, you know, you're payer agnostic, but,  
20 you know, we don't -- what does that mean per se?  
21 Because really you're looking for Medicaid patients. You  
22 know, if they don't recognize that you're payer agnostic  
23 because -- unless they recognize the value of your  
24 services.

1                   Now, do you -- can you determine that for  
2 Medicaid?

3                   MR. CLOCH: So with Medicaid, yes.

4                   So Medicaid, with Medicaid, it's no longer with  
5 Medicaid, it's with Cincinnati Shareholders. So the  
6 lines have been switched to be Cincinnati Shareholders,  
7 so IlliniCare, Meridian, Blue Cross Blue Shield, Cigna,  
8 Aetna, Humana. I think I got them all right.

9                   So those are the negotiations and conversations  
10 we're having actively with those firms to talk about the  
11 level of care and negotiate level of care pricing for  
12 their membership.

13                   So I don't know if that makes any more sense,  
14 so if you're looking at the company dialogue, these are  
15 all six of the payers who are participating in those  
16 programs.

17                   VICE CHAIRMAN HAYES: Okay. I understand now  
18 what you're saying.

19                   MR. SHEETS: Mr. Hayes, let me try to add to  
20 that.

21                   The way the system worked in the old days,  
22 whether they were Medicaid or not, or whether they were  
23 Medicare and Medicaid, you would go to the hospital and  
24 have a surgery. You have a hip, knee problem, whatever,

1 and then you would go to rehab in the hospital or rehab  
2 in the nursing facility. Those needs for short-term stay  
3 for that population are still there; we just don't --

4 They need to understand incentive to payers,  
5 which they're beginning to do, like the doctor was  
6 talking about earlier, to getting people out of the  
7 hospital quicker and getting them into the rehab facility  
8 quicker, and then they get home quicker and then  
9 everybody saves money.

10 So it's the same model for Medicaid as it is  
11 for all the other payers, it's just that Medicaid is  
12 moving much slowly towards that.

13 MR. CLOCH: And let me just give it to you real  
14 fast.

15 So we operate two facilities right now, one in  
16 Arlington Heights, which is short-term, and the other one  
17 is in Libertyville. That's a combination of --

18 Like, a typical nursing home's got a short-term  
19 section for disability and a Medicaid section. So we're  
20 very careful on residents that come within Arlington  
21 Heights that we think that they're going to need a  
22 custodial stay, we'll soon ask that they go to a facility  
23 that has a Medicare unit and a custodial unit because we  
24 only have one unit. We only serve the short-term

1 population.

2 So we want to make sure that they get the best  
3 experience, so we might suggest that they go to  
4 Libertyville, where they can come in, stay short-term,  
5 and then transition to a long-term or a custodial.

6 So it really changes the -- you know, we're  
7 really trying to target the service level more than  
8 anything.

9 I hope that helps.

10 VICE CHAIRMAN HAYES: Thank you.

11 CHAIRWOMAN OLSON: Okay. Any call for a vote  
12 here? Roll call vote?

13 MR. ROATE: Thank you, Madam Chair.

14 Motion made by Senator Demuzio; seconded by  
15 Mr. Sewell.

16 Senator Burzynski?

17 MEMBER BURZYNSKI: Thank you. You know, while  
18 I understand the concept, I think, of the transitional  
19 care and the reason that more people are wanting to go to  
20 that, I still am very concerned today, even with the  
21 process, especially as it relates to the financial aspect  
22 here, and because of that, I'm going to vote no.

23 MR. ROATE: Thank you.

24 Senator Demuzio.

1                   MEMBER DEMUZIO: Okay. Well, I too, have some  
2 concerns like Senator Burzynski. However, there are  
3 several areas where you haven't met that criteria as we  
4 look through financial and whatever.

5                   However, I did notice that in the State Report  
6 there is a five-year growth projection, all right, for  
7 those that are in the aging population.

8                   So because of that, and only because of that,  
9 I'm going to give you the yes vote.

10                  MR. ROATE: Thank you.

11                  Mr. Galassie.

12                  MEMBER GALASSIE: After a great deal of  
13 contemplation on this, and I will tell you, you have  
14 certainly educated me well on the transitional care  
15 concept, not only today but previously, and I strongly  
16 support it and believe in it and I'm not even sure it's  
17 the future, I think it's now, and I think the reality for  
18 our existing providers, as difficult as this may be, it  
19 is the reality of what's coming, so change occurs.

20                  I also believe I had some reservations on your  
21 finances, and I would hope in the future we could have it  
22 secured in writing -- I guess the yin and yang between us  
23 and the bank -- but it certainly makes their role a  
24 little easier; it makes our role a little harder.

1 All that having been said, I vote aye.

2 MR. ROATE: Thank you.

3 Justice Greiman.

4 MEMBER GREIMAN: I had the same kind of  
5 reservation about this as Dale, and we've learned a great  
6 deal in this discussion.

7 I'm kind of intrigued by the fact that we have  
8 one owner seeking to be 16 minutes away from each other  
9 and theoretically doing the same thing. It is in  
10 conflict with each other and stealing each other's  
11 people, and so I think I'm going to vote aye, just to let  
12 it go by and see what happens.

13 MR. ROATE: Thank you.

14 Mr. Hayes.

15 VICE CHAIRMAN HAYES: Well, I'm very concerned  
16 about the State Board Report and the service  
17 accessibility and unnecessary duplication of service, and  
18 it's laid out very well in the State agency report, and  
19 also the availability of funds is another concern for me,  
20 but -- and the financial viability, I think they've  
21 basically answered that, and the reasonableness of  
22 project costs, I think they've reasonably answered that  
23 in the report, but I still come back to my concern about  
24 these unnecessary duplication of services and service

1 accessibility, so I'm going to vote no.

2 MR. ROATE: Thank you.

3 Mr. Johnson.

4 MEMBER JOHNSON: To be redundant a little, I  
5 share some of the same concerns as some of the other  
6 Board Members about the financing, and as the Chairman  
7 mentioned, this whole concept in the nursing home  
8 industry around these dead beds and the quandary that you  
9 put us in in trying to determine if it is a real  
10 unnecessary duplication of services or not, but I share  
11 your angst with the managed care and what that means for  
12 various health care industries in the health sphere.

13 I'm going to vote in favor of this.

14 MR. ROATE: Thank you.

15 Mr. McGlasson.

16 MEMBER MCGLASSON: I'm going to vote yes, based  
17 on the fact that from what I've learned today and through  
18 personal experience that the transitional care model is a  
19 worthy goal.

20 MR. ROATE: Thank you, sir.

21 Mr. Sewell.

22 MEMBER SEWELL: I vote no for the reasons  
23 stated by Mr. Hayes. I'm still not convinced on the  
24 service accessibility, the unnecessary duplication of

1 service, and the availability of funds. So I vote no.

2 MR. ROATE: Thank you, sir.

3 Madam Chair.

4 CHAIRWOMAN OLSON: I'm going to vote yes. I  
5 think it's on the record before us it's a transitional  
6 model. Based on the fact there's a 138 bed need and not  
7 a bed surplus, I vote yes.

8 MR. ROATE: That's six votes in the  
9 affirmative; three in the negative.

10 CHAIRWOMAN OLSON: The motion passes.

11 Congratulations.

12 (Applause.)

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CHAIRWOMAN OLSON: The next project is Project No. 16-002, Transitional Care of Fox Valley.

I have a motion to approve Project No. 16-002, Transitional Care of Fox Valley, to establish a 68-bed long-term care facility.

MEMBER DEMUZIO: So move.

CHAIRWOMAN OLSON: I have a motion. Do we have a second?

MEMBER GALASSIE: Second.

CHAIRWOMAN OLSON: I believe it will be the same Applicants at the table who are already sworn in.

Mr. Constantino?

MR. CONSTANTINO: Thank you.

Thank you, Madam Chairwoman.

The Applicants are proposing the establishment of a 68-bed long-term care facility in Aurora, Illinois, at a cost of approximately 15.9 million dollars, with a completion date of December 31st, 2018.

We did receive a comment on the State Board staff report that I've put in front of you for Project 16-002. It pretty much says the same thing as 15-056. We did have findings on 16-002 similar to the findings on 15-056.

1 CHAIRWOMAN OLSON: Correct, but my question to  
2 you, before I allow you to go further, are we going to  
3 now change our bed need or do we not do that until after?

4 MR. CONSTANTINO: No.

5 CHAIRWOMAN OLSON: We don't do that until after  
6 this meeting.

7 MR. CONSTANTINO: That's correct.

8 CHAIRWOMAN OLSON: All right. Thank you.

9 Mr. Sheets, would you introduce the people at  
10 the table so it's in the record again?

11 MR. SHEETS: Sure. My name is Chuck Sheets.  
12 I'm the attorney on behalf of the Applicant. I have to  
13 my left, Mr. Brad Haber, and to his left, Mr. Brian  
14 Cloch, and to his left, Ms. Anne Cooper, also from my  
15 office.

16 CHAIRWOMAN OLSON: Okay. Comments for the  
17 Board?

18 MR. SHEETS: Well, we can -- we would have the  
19 same response to the comments that were said earlier for  
20 the earlier Applicant.

21 CHAIRWOMAN OLSON: Okay. Everybody understand  
22 that?

23 Doctor, did you have a comment?

24 EX OFFICIO MEMBER GOYAL: Yes. Thank you,

1 Madam Chair, for allowing me this question. Actually,  
2 this is for the Staff.

3 What if there were three and four applicants  
4 for similar number of beds at this meeting? Would we  
5 approve them all, even though the total geographical area  
6 only allows for so many beds to be built?

7 MR. CONSTANTINO: Yes.

8 EX OFFICIO MEMBER GOYAL: That surprises me,  
9 but thank you.

10 CHAIRWOMAN OLSON: Okay. So other questions.  
11 John?

12 VICE CHAIRMAN HAYES: Thank you, Madam Chair.

13 Could you explain -- now, the financing for  
14 this project is different from the project -- or it's  
15 different. So can you explain the financing and the  
16 equity for this project?

17 MR. HABER: Yeah.

18 So we essentially have the same philosophy and  
19 the same thoughts on this application. What we attempted  
20 to do here, it seemed like the Board appreciated the HUD  
21 financing letters. We went out and we also got a HUD  
22 financing letter for this transaction as well. We still  
23 do have the same financial institutions available as the  
24 other transaction; we just happened to add a HUD

1 financing letter as well to this one, which is very  
2 similar to other Applicants. We thought that that would  
3 make it more appealing.

4 VICE CHAIRMAN HAYES: Because a HUD bill just  
5 has guarantee on a loan from a financial institution.

6 MR. HABER: Say that again?

7 VICE CHAIRMAN HAYES: Well, a HUD bill provides  
8 a guarantee on a loan from a financial institution.

9 MR. HABER: Correct, yes. It's a HUD-insured  
10 loan. If you have specific questions on HUD, one of our  
11 partners is a co-Applicant and he's here sitting behind  
12 me, and he's got 700 million dollars of HUD loads, so he  
13 can probably answer a lot of HUD questions as well.

14 VICE CHAIRMAN HAYES: But that's why you did  
15 not -- the availability of funds --

16 Because, basically, the Capital Funding, LLC,  
17 did not provide a firm commitment that alone will be  
18 granted should the project be approved.

19 MR. HABER: Yes. It is the same as the other  
20 deal.

21 So what happens is, in any commitment like  
22 this, it usually will reference -- you can look at any  
23 HUD commitment that you're looking at at this stage of  
24 the game and it will say "for discussion purposes only"

1 at this point. It will lay out the basic terms or  
2 transactions, but always subject to final approval of  
3 HUD.

4 VICE CHAIRMAN HAYES: And what will be the  
5 percentage of cash and what will be the -- of loan to  
6 equity. What is the percentage of equity?

7 MR. HABER: So this transaction, this will have  
8 about 25 percent when it's all said and done, because  
9 what happens is, you're at 80 percent loan to value or 90  
10 percent loan to cost. I think it's about a million nine  
11 or something, but there's another two plus million  
12 dollars of expense that is not in this budget because  
13 it's not allowed for this project until the application  
14 is filled out.

15 We, once again, will have over four million  
16 dollars, within to four and five million dollars of  
17 equity in this transaction.

18 There are very subtle differences in total  
19 overall cost. The land for this project is roughly about  
20 \$300,000 more.

21 VICE CHAIRMAN HAYES: Okay. And what date --  
22 this project will be completed December 31st of 2018.  
23 Now, is that correct? Because our report says the  
24 project will not be -- the completion date is June 30,

1 2019. What is the date?

2 MR. HABER: Well, you know, obviously, we're  
3 going to try to open up as quickly as possible. I  
4 believe we have three years from the point where we  
5 submit our application to opening, and that's ultimately  
6 the goal. So we're going to target both of these for  
7 December of 2018.

8 VICE CHAIRMAN HAYES: And because of  
9 differences, could you lay that out?

10 Well, this is about a hundred thousand dollars  
11 more expensive. Is it because of the -- this project is  
12 less -- I mean, you expect to open this six months later  
13 at a minimum.

14 MR. HABER: Yeah. That's -- the difference in  
15 costs are really due to the land and so forth, the  
16 overall project costs. This land is about \$300,000 more,  
17 very subtle differences. The actual construction costs  
18 we expect to be very similar.

19 VICE CHAIRMAN HAYES: The purchase of the land  
20 has been \$300,000 more.

21 MR. HABER: Roughly, yeah.

22 VICE CHAIRMAN HAYES: Well, thank you.

23 CHAIRWOMAN OLSON: Other questions.

24 Seeing none, I'd ask for a roll call vote.

1 MR. ROATE: Motion made by Senator Demuzio;  
2 seconded by Mr. Galassie.

3 Senator Burzynski.

4 MEMBER BURZYNSKI: Thank you. I will vote no  
5 based on the staff findings relative to Part 1125 and  
6 Part 1125.8.

7 MR. ROATE: Thank you.

8 Senator Demuzio.

9 MEMBER DEMUZIO: Again, I'm going to go ahead  
10 and give you a yes vote based -- even though there's some  
11 Staff findings on this and -- but, again, it's because  
12 there's a projection of going up five years on need,  
13 particularly for the aging, so I'll give you a yes vote.

14 MR. ROATE: Thank you.

15 Mr. Galassie.

16 MEMBER GALASSIE: Yes, prior comments made.

17 MR. ROATE: Thank you.

18 Justice Greiman.

19 MEMBER GREIMAN: I'm going to vote yes because  
20 I want to see them beat the competition.

21 (Laughter.)

22 MR. ROATE: Mr. Hayes.

23 VICE CHAIRMAN HAYES: You know, I have concerns  
24 as I may have previously stated, but I have concerns

1 about the service accessibility, the unnecessary  
2 duplication of service, and then also the availability of  
3 funds. I think they have explained the financial  
4 viability. And another thing that does concern me is  
5 that, of course, we are very dependent on their income  
6 projections and things like that. We haven't -- you  
7 know, this is something they really don't provide a lot  
8 of detail and assumptions on their -- you know, when they  
9 do their projections. But I think they've -- I answered  
10 the financial viability and the reasonableness of public  
11 project costs, so I'm going to vote no for the reasons  
12 I've just stated.

13 MR. ROATE: Thank you.

14 Mr. Johnson.

15 MEMBER JOHNSON: For previously stated reasons,  
16 I'm going to vote yes.

17 MR. ROATE: Thank you.

18 Mr. McGlasson.

19 MEMBER MCGLASSON: For previously stated  
20 reasons, I'm going to vote yes.

21 MR. ROATE: Mr. Sewell.

22 MEMBER SEWELL: I vote no for -- because of  
23 service accessibility and unnecessary duplication of  
24 service and availability of funds.

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MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: I vote yes based on the 138 bed need and HSA-7 and the fact that there is, according to the State Board staff report, no bed surplus in that HSA.

MR. ROATE: Thank you, Madam Chair.

That's six votes in the affirmative; three in the negative.

CHAIRWOMAN OLSON: The motion passes.  
Congratulations again.

(Applause.)

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CHAIRWOMAN OLSON: Next, we have Project 16-006, Alden Estates of Bartlett.

May I have a motion to approve Project 16-006, Alden Estates of Bartlett, to establish a 68-bed long-term care facility?

MEMBER BURZYNSKI: So move.

MEMBER GREIMAN: Second.

CHAIRWOMAN OLSON: The Applicant will be sworn in.

(Five witnesses sworn.)

Mr. Constantino, your report, please.

MR. CONSTANTINO: Thank you, Madam Chair.

The Applicants are proposing to establish a 68-bed facility in Bartlett, Illinois, at a cost of approximately 19 million dollars. The anticipated completion date is December 2019. One letter of opposition was received. No public hearing was requested.

We have findings related to service access, the duplication of service, and financial viability.

Thank you, Madam Chairwoman.

CHAIRWOMAN OLSON: Thank you, Mr. Constantino.

Comments for the Board?

1 MS. SCHULLO: Good afternoon.

2 Madam Chairman and Members of the Board, I'm  
3 Randi Schullo, R-A-N-D-I, S-C-H-U-L-L-O.

4 I'm pleased to have with me today Joan Carl,  
5 Vice President of Alden Management Services; John Kniery,  
6 our CON consultant; Joe Ourth, our CON consult; and also  
7 Charles Foley.

8 As always, I would first like to thank  
9 Mr. Constantino and Mr. Roate for their work on the State  
10 agency report.

11 We are proposing to construct a 68-bed  
12 long-term care facility in Bartlett. We have recently  
13 appeared before you and discussed who Alden is.  
14 Hopefully, you are aware of the services and quality we  
15 provide to our residents. Hopefully, you also know that  
16 we provide care to all residents from all payer sources.  
17 We have continually reported our commitment to patient  
18 care.

19 We have over 800 units of affordable senior  
20 housing, serving seniors on fixed incomes, as well as  
21 Alden's overall 75 percent Medicaid population. We have  
22 a 46-year track record of providing this care.

23 You, the Board, have calculated that for this  
24 planning area, there's a need for these 68 additional

1 beds. We would like to have proposed a larger facility;  
2 however, we abide by your bed inventory.

3 Alden has never sought a CON to construct a new  
4 facility, unless you, the Board, has calculated a need  
5 for additional beds. This facility complies with your  
6 established bed need.

7 The State Board Staff made positive findings on  
8 all review criteria except three. Two of the findings  
9 related to other facilities operating through a targeted  
10 utilization. We will address these issues in greater  
11 detail but first want to discuss the financial viability  
12 issue.

13 The State Board Report correctly notes that we  
14 meet most but not all the financial viability ratios. We  
15 do not meet the cushion ratio and the days cash on hand.

16 The State Board Report further notes, however,  
17 that Alden has a track record of successfully obtaining  
18 financing for all of its projects.

19 At the last meeting, our CFO testified before  
20 you how each of our projects are financially -- I'm so  
21 sorry -- are financially viable.

22 Structured to meet the underwriting  
23 requirements for the federal HUD loan guarantee, we're  
24 putting in over five million dollars of family money into

1 this transaction. We, like you, have strong reason to  
2 want financial viability.

3 Alden is not a new speculative developer. We  
4 are experienced care providers that have examined this  
5 project closely and are confident that we can obtain  
6 financing and this project is viable in both the long and  
7 short term.

8 On the two projects before us today, there was  
9 considerable discussion about what should be done by the  
10 Board as a calculated bed need that some providers are  
11 operating low targeted utilization. As you determined in  
12 the past just minutes ago, it can be appropriate to  
13 approve projects despite underutilization.

14 Our project reflects even higher compliance  
15 with your standards and has only minimal opposition as  
16 compared to the one you just approved.

17 We are pleased that there was only a single  
18 letter of opposition on our project, no public hearing  
19 requested, and no public comment today. The one letter  
20 was from a facility in a different planning area.

21 The facility provides good care, and not  
22 surprising, operating at 87.3 percent of the 90 percent.  
23 The facility is only four residents away from meeting  
24 targeted utilization. No other facilities registered any

1 opposition.

2 The number of access beds is reflected in the  
3 State Board Report as of 2014. Our project is not  
4 scheduled to open until 2019. Your bedding calculation  
5 projects that there will be a greater need in the future  
6 than there is now. This is particularly true of DuPage  
7 County, where the population of seniors is expected to  
8 grow at a much faster rate. If you trust the Board's  
9 bedding methodology, as we do, you should trust that by  
10 2019 when the facility opens, there will be fewer access  
11 beds.

12 The future need for additional beds is  
13 particularly evident in DuPage County where senior  
14 population projections from the Review Board show, for  
15 example, that between 2015 and 2020 in DuPage, 65 plus  
16 residents will grow by 25 percent, as compared to 16  
17 percent statewide. The 75 plus population will grow 21  
18 percent in DuPage, compared to 11 percent for the state  
19 overall by the first year of operation of this facility.

20 Current underutilization of the existing  
21 facilities may be relevant, but it should not mean that  
22 you automatically reject an application that otherwise  
23 meets the Board's review criteria.

24 In conclusion, we are pleased to bring to you

1 this project that will serve the community of Bartlett.

2 In our project response to the Board's  
3 calculated needs for additional beds in the area, we have  
4 developed a project that meets most of your review  
5 criteria and certainly those we can control.

6 There is no public hearing requested, no public  
7 comment, and only one letter of opposition -- again, not  
8 from a facility in our planning area.

9 We know the facilities we establish and the  
10 quality of service we provide our residents. This is a  
11 good project and we ask you to approve this project.

12 We're happy to address any questions you may  
13 have.

14 CHAIRWOMAN OLSON: Thank you.

15 Questions from Board Members?

16 VICE CHAIRMAN HAYES: Thank you, Madam  
17 Chairman.

18 Is this the -- would you describe this facility  
19 as a transitional care facility?

20 MS. SCHULLO: This facility will be a  
21 combination of transitional care, but we'll also be able  
22 to accommodate long-term residents as well. So we'll be  
23 duly certified for both Medicare and Medicaid, and we  
24 will take care of the full continuum of care.

1 I also wanted to note one other thing. On this  
2 campus in front of our development, there also is an  
3 assisted living facility that's being built, and the  
4 Village of Bartlett had requested when we were looking  
5 for a location to build, they liked the idea that we were  
6 on the same campus.

7 VICE CHAIRMAN HAYES: So there's an assisted  
8 living facility by another company or a hospital  
9 building?

10 MS. SCHULLO: Correct. It's a separate entity;  
11 a separate company, not Alden.

12 VICE CHAIRMAN HAYES: Okay. Thank you.

13 Well, I've got to get my thoughts here. Sorry  
14 about that.

15 You know, why did you come up with a number of  
16 68 beds? How is that determined?

17 MS. SCHULLO: Well, we, number one, so we're  
18 looking at sites, and the fact is, the site could only  
19 fit about that limited amount of beds. It's behind  
20 another assisted living facility, so 68 was the number  
21 that we came up with based on your rules.

22 VICE CHAIRMAN HAYES: And what does that -- is  
23 that one-half of the bed need of 138, or how did our  
24 rules affect that?

1 MS. SCHULLO: Right.

2 We tried to abide by your rules and that's what  
3 we follow, so we had been looking to build a little bit  
4 of a larger facility. However, once Mr. Cloch had  
5 submitted his first application, we downsized the beds  
6 that we had.

7 VICE CHAIRMAN HAYES: Okay.

8 So, you know, this is not a transitional care  
9 facility. Do you have any problem with other  
10 transitional care facilities, that type of model?

11 MS. SCHULLO: When we were just before you last  
12 month and we were talking about our project, which is on  
13 the Silver Cross Campus, that project will primarily be  
14 transitional care.

15 This project will be a mixture of both  
16 transitional care, so it will serve the post-acute care  
17 model, and we will also have some long-term care  
18 residents in this building as well.

19 VICE CHAIRMAN HAYES: Thank you.

20 CHAIRWOMAN OLSON: Mr. Burzynski?

21 MEMBER BURZYNSKI: Thank you.

22 This is directed to Mike.

23 Since we've had so much discussion about the  
24 need for 138 beds, long-term care beds, how do we define

1 long-term care?

2 Since we're talking transitional care, it's 15  
3 days, it seems. That's what we've been talking here.  
4 What is long-term care? Can it be just 15 -- can it just  
5 be 15 days?

6 MR. CONSTANTINO: Yeah. We use the license  
7 whether they're licensed as long-term care beds, and that  
8 15-day period, those beds will be licensed as long-term  
9 care. Yes. No matter their length of stay, they're  
10 going to be licensed as long-term care.

11 MEMBER BURZYNSKI: Thank you.

12 CHAIRWOMAN OLSON: Any questions?

13 Mr. Sewell.

14 MEMBER SEWELL: Yeah, I'd like to ask Mike a  
15 question about this ten percent or 20-bed rule that's in  
16 your -- stated in his report on financial viability.

17 I thought that was for contingency health.  
18 What is that?

19 MR. CONSTANTINO: What I'm referring to here is  
20 Alden had submitted a project for a number of beds that  
21 are greater than ten percent of 20 beds and the cost for  
22 that project for a CON, and it was approved by the Board,  
23 and they were able to finance it.

24 What I'm trying to tell you there in that

1 explanation under financial viability, even though we're  
2 negative on that criteria, Alden has demonstrated the  
3 ability to finance since 2007 five different projects,  
4 and one of those projects was for additional beds at  
5 their Shorewood facility.

6 MEMBER SEWELL: Thank you.

7 MS. MITCHELL: And if I may, just to explain a  
8 little bit. There was a rule that -- there is a rule  
9 that the facility is ten percent beds, 20 percent, you  
10 can add up to a certain number of beds without having to  
11 go through a hearing.

12 CHAIRWOMAN OLSON: Senator?

13 MEMBER DEMUZIO: Yes. I just have a quick  
14 question here. It's regarding some of your facilities.

15 You have a number of facilities, it looks like  
16 maybe what, 21, located out? Okay.

17 I'm looking at a statement here that says that  
18 you have had violations in some of your other facilities,  
19 an "A" violation. It's under Criteria Background and the  
20 Applicant.

21 Do you have any idea? Can you tell me what  
22 those violations, what an "A" means?

23 MR. KNIERY: My name is John Kniery,  
24 K-N-I-E-R-Y, health care consultant for the project.

1 Thank you, Senator.

2 In the application, we did disclose --

3 MEMBER DEMUZIO: Page 96 through -- well, right  
4 above Table 6 is where the comment is. It says you have  
5 not had any -- in the three years preceding the filing of  
6 your certificate of need, there were no violations, but  
7 there are a few other facilities that have received  
8 violations of the "A" level from the Illinois Department  
9 of Public Health.

10 MR. KNIERY: For a full disclosure, I believe  
11 we did disclose that -- well, first of all, we listed all  
12 the facilities that are related that have had no  
13 violations.

14 MEMBER DEMUZIO: Right.

15 MR. KNIERY: But it does require you to look  
16 backwards three years, and we did, I think --

17 I don't know the timeframe, Randi, but we have  
18 had one, I think it was two years and one's three, that's  
19 going to fall off. It maybe has fallen off by now.

20 MEMBER DEMUZIO: Do you know what those were?

21 MR. KNIERY: Let me find the data and I'll try  
22 to have Randi address that.

23 MEMBER DEMUZIO: You can come back and let us  
24 know if there were any other questions. I just -- for my

1 own interests, I was curious what a level "A" was from  
2 the Illinois Department of Public Health.

3 MR. KNIERY: "A" is the level that we have to  
4 report back to you and let you know.

5 MEMBER DEMUZIO: Back to the department?

6 MR. KNIERY: Yeah, for the project. Yes.

7 MEMBER DEMUZIO: And if you could find that  
8 out, that would be great, if you know what that is, what  
9 they have.

10 CHAIRWOMAN OLSON: Other questions?

11 Go ahead, John.

12 VICE CHAIRMAN HAYES: Thank you, Madam  
13 Chairman.

14 Just a quick question. This project will cost  
15 over 19 million dollars and it's also almost four years  
16 for it to be completed. It seems like some of the other  
17 projects that we've looked at today or other days, that  
18 sounds very expensive. Could you go over why that is?

19 MS. SCHULLO: We may possibly have this  
20 facility completed sooner, but we still have to finalize  
21 the zoning process and the plans and specifications, so  
22 we just built in a little more time.

23 VICE CHAIRMAN HAYES: More time to complete the  
24 project?

1 MS. SCHULLO: Correct.

2 VICE CHAIRMAN HAYES: But the cost of it, you  
3 know, is maybe three million dollars above some  
4 facilities.

5 MR. KNIERY: Well, the project is larger than  
6 the other facilities I believe you're mentioning. So on  
7 a square foot basis, I believe we're very comparable and  
8 in accordance with the rules.

9 CHAIRWOMAN OLSON: Let's be careful not to  
10 compare.

11 MR. KNIERY: I agree.

12 Yeah. So it is within your -- I believe  
13 there's a finding on that, but the total project costs,  
14 you're absolutely right, but we are building a much  
15 larger facility and that's really why -- the square  
16 footage is really the reason why the costs are higher,  
17 and on a per square footage basis, we are consistent.

18 VICE CHAIRMAN HAYES: Okay. Thank you.

19 CHAIRWOMAN OLSON: Other questions?

20 Can I call for roll call vote? Senator?

21 MEMBER DEMUZIO: Go ahead. That's fine. I  
22 don't think they're going to be able to come up with an  
23 answer. That's okay.

24 MR. KNIERY: Senator, I have them listed, but I

1 don't know what they are. I would have to --

2 MEMBER DEMUZIO: You have four of them.

3 MR. KNIERY: Yes, yeah.

4 MEMBER DEMUZIO: And it just says that there  
5 are four of those facilities that received level "A", and  
6 if you could, at some point if you'll come and tell me.

7 MR. KNIERY: We definitely can.

8 MEMBER DEMUZIO: Okay. I would ask that a roll  
9 call vote be tallied.

10 CHAIRWOMAN OLSON: Roll call vote, please?

11 MR. ROATE: Thank you, Madam Chair.

12 Motion made by Mr. Galassie; seconded by  
13 Justice Greiman.

14 Senator Burzynski.

15 MEMBER BURZYNSKI: Thank you. I think the  
16 findings have been pretty well addressed, and based on  
17 the need for 138 long-term care beds, I will vote yes.

18 MR. ROATE: Thank you.

19 Senator Demuzio.

20 MEMBER DEMUZIO: Well, I'm sure you're going to  
21 give me at some point -- over the next year, I'll see you  
22 many times here, so you can tell me what those are. I  
23 was curious as to what an "A" is.

24 But I'm looking at the criteria -- some of the

1 findings from the State Board. I'm still going to go  
2 ahead and give you a yes vote, based on that, that there  
3 is a five-year projection, just like the rest of them,  
4 that there's a need for population for the elderly. At  
5 my age, I may be looking at that longer, okay?

6 Thank you.

7 MR. ROATE: Thank you.

8 Mr. Galassie.

9 MR. GALASSIE: Based upon comments made, I vote  
10 aye.

11 MR. ROATE: Thank you.

12 Justice Greiman.

13 MEMBER GREIMAN: Based on comments made, I also  
14 vote aye.

15 MR. ROATE: Thank you.

16 Mr. Hayes.

17 VICE CHAIRMAN HAYES: Based on the service  
18 accessibility and the unnecessary duplication of  
19 services, I'm going to vote no.

20 MR. ROATE: Thank you.

21 Mr. Johnson.

22 MEMBER JOHNSON: Based on the comments made,  
23 I'll vote yes.

24 MR. ROATE: Thank you.

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Mr. McGlasson.

MEMBER MCGLASSON: Based on the anticipated future needs, I vote yes.

MR. ROATE: Thank you.

Mr. Sewell.

MEMBER SEWELL: I vote no for reasons stated by Mr. Hayes.

MR. ROATE: Thank you.

Madam Chair.

CHAIRWOMAN OLSON: I vote yes based on the 138 bed need and the no-bed surplus in HSA-7.

MR. ROATE: That's seven votes in the affirmative; two in the negative.

CHAIRWOMAN OLSON: Motion passes.  
Congratulations.

(Applause.)

We're going to take about a ten minute break.

(A ten-minute recess was taken.)

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CHAIRWOMAN OLSON: University of Chicago  
Medical Center.

May I have a motion to approve Project 16-008,  
University of Chicago Medical Center, to modernize and  
expand clinical services?

MEMBER MCGLASSON: So move.

MEMBER BURZYNSKI: Second.

CHAIRWOMAN OLSON: The Applicant will please be  
sworn in.

(Six witnesses sworn.)

Mr. Constantino, your report?

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The Applicants are proposing a major  
modernization that entails an increase of approximately  
50 percent of their medical/surgical beds, from 338 beds  
to 506 beds, or 168 beds, and an increase in their  
intensive care beds from 126 to 146 beds, or 20 beds.

Additionally, the Applicants are proposing to  
relocate and expand the adult emergency department from  
36 stations to 41 stations and seek Level I trauma  
designation from the Illinois Department of Public  
Health, should this project be approved.

The total cost of the project is approximately

1 270 million dollars, and the Applicants are anticipating  
2 a completion date of June 20, 2022.

3 There is no opposition and no request for a  
4 public hearing. A number of support letters were  
5 received from the community, which we've listed in your  
6 report.

7 There were -- we believe the Applicant's  
8 proposal does not meet the following criteria: The  
9 Applicants are currently approved for 338  
10 medical/surgical beds and 126 intensive care beds.  
11 Historic utilization will justify 343 medical/surgical  
12 beds at the target occupancy of 90 percent and not the  
13 506 medical/surgical beds they have requested, and 141  
14 intensive care beds and not the 146 beds being requested  
15 at target occupants of 60 percent. Historical  
16 utilization would justify five additional med/surg beds  
17 and 15 intensive beds at target occupancy.

18 Finally, we note there's a -- the  
19 reasonableness of project costs exceed our standard by  
20 approximately \$115.07.

21 Thank you, Madam Chairwoman.

22 CHAIRWOMAN OLSON: Thank you, Michael.

23 Mr. Ourth, would you please introduce everybody  
24 at the table and then we'll ask for your comments.

1 MR. OURTH: Madam Chair, thank you.

2 MS. O'KEEFE: Members of the Board, my name is  
3 Sharon O'Keefe, and I serve as President of the  
4 University of Chicago Medical Center.

5 Joining me here today is, to my right, Joe  
6 Ourth, our CON legal counsel, and down the table is John  
7 Beberman, Director of the Capital Budget for University  
8 of Chicago Medical Center; Dr. Vokes, our Chairman of  
9 Medicine; Brenda Battle, who is Vice President for Care  
10 Delivery Innovation and actually serves as Head of our  
11 Urban Health initiative; and towards the end is Dr. Doug  
12 Dirschl, our Chairman of Orthopedics and also a trauma  
13 surgeon by trade.

14 CHAIRWOMAN OLSON: Thank you.

15 Comments for the Board?

16 MS. O'KEEFE: Yes. Thank you.

17 Before I begin, I'd like to thank  
18 Mr. Constantino and other members of the Board and their  
19 staff for the work on the SPR.

20 I really was concerned as to how I could ensure  
21 I communicated the importance of this project, not only  
22 to the medical center, but also to our community. So I  
23 began actually thinking about how to prepare my remarks  
24 over the last couple of weeks, and in earnest, last

1 Thursday, just five days ago.

2 As I came in to work last Thursday, I started  
3 my day as I did most days that I do. I reviewed the  
4 beds -- the daily bed report that comes out every single  
5 day. As I looked down at that report, I noted that we  
6 were actually 100 percent full last Thursday. Every  
7 single bed in the medical center was full. We had no  
8 beds, and at this time I knew I could guarantee that the  
9 emergency department was going to be backlogged with  
10 patients. So I actually just left my office and walked  
11 over to the ED to fully appreciate what our staff and our  
12 patients were experiencing on that day.

13 When I arrived in the emergency department, of  
14 our 36 bays that we have, 24 were filled with patients  
15 awaiting beds within our medical center. Of those 24,  
16 six of these patients needed intensive care level of  
17 care, including one elderly patient who arrived the night  
18 before in septic shock and was still waiting that morning  
19 for a bed.

20 I then actually looked at the list of patients  
21 being transferred into our hospital. We had seven  
22 community hospitals with pending transfers. Four of  
23 those actually also required intensive care beds.

24 And lastly, I looked at our operating room

1 schedule on that day. We had 41 elective surgical  
2 patients coming in that day that we had committed,  
3 operated on, and committed a bed to.

4 When I totaled up the number of patients on  
5 that morning, we needed 72 more beds and we had zero  
6 available that morning. Even with 72 more beds, we would  
7 continue to be at a hundred percent occupancy. The beds  
8 needed last Thursday were approximately half of the beds  
9 requested by this project, and last Thursday did not  
10 account for the volume anticipated with the addition of  
11 our Level I trauma center, the expansion of our emergency  
12 department, and the continued growth of our specialty  
13 care services.

14 As you heard from many of our clinicians  
15 earlier this morning, these are not just numbers. These  
16 are very real patients in need of serious care.  
17 Unfortunately, the long wait times and the lack of beds  
18 at the medical center are no longer isolated events.  
19 They have become the norm at our medical center.

20 During calendar 2015, our average utilization  
21 reached 94 percent, one of the highest in the state. For  
22 2015, we exceeded the state's utilization standards on  
23 310 days of the year and actually opened at 100 percent  
24 occupancy on 172 days of the year. These utilization

1 statistics surpassed state standards and are  
2 operationally unsustainable.

3 From our community's perspective, what does  
4 this mean? This means ambulances are instructed to  
5 bypass the medical center, transfers from community  
6 hospitals cannot be accepted, and patients sit in our  
7 emergency department, worried and frightened, for 12, 24,  
8 and often many more hours. This is unacceptable and our  
9 South Side community deserves much better.

10 (Applause.)

11 Our project represents a substantial -- our  
12 project represents a substantial investment in the health  
13 care needs of the South Side of Chicago and would  
14 increase access to specialty, emergency, and trauma  
15 service.

16 Input from community members actually helped  
17 shape the plan. This was a true partnership and helped  
18 bring us to a very good conclusion and what I believe to  
19 be an excellent plan.

20 It's a complex project, so, first, let me  
21 describe the facilities component, and then I'll make  
22 some comments on the clinical services that will be  
23 provided within these facilities.

24 The facilities component consists of two major

1 construction projects. First, we will relocate and  
2 expand our adult emergency department to a space  
3 immediately adjacent to the Center for Care and  
4 Discovery. This will improve patient safety by ensuring  
5 patients in need of rapid transfer to an operating room  
6 will have a short travel time. Treatment bays will  
7 increase from 36 to 41, including four specialized trauma  
8 resuscitation bays.

9           The new facility will provide imaging equipment  
10 that is dedicated to emergency and trauma patients. The  
11 location, floor plan, and design of the adult ED will be  
12 clinically superior and more efficient than our current  
13 space, allowing for faster medical care and shorter wait  
14 times for patients.

15           Second, we proposed to gut and redevelop the  
16 Mitchell Hospital to house 168 medical/surgical beds and  
17 20 intensive care beds. The redevelopment of Mitchell  
18 Hospital would convert semi private rooms to private  
19 rooms, upgrade the facility infrastructure to accommodate  
20 the advanced technology needed to care for high acuity  
21 patients and ensure that the patient environments offer  
22 the same standards as our Center for Care and Discovery.

23           The Mitchell Hospital, in addition, will be  
24 designed to deliver a broad spectrum of cancer care --

1 cancer services allowing the CCD to be devoted to  
2 patients requiring procedure-based care, such as trauma,  
3 cardiac surgery, orthopedics, and neurosurgery.

4 Additional bed capacity is the cornerstone of  
5 our plan. Without a significant expansion in our bed  
6 base, our commitments to improve the access to specialty  
7 care, expand emergency services, and establish a Level I  
8 adult trauma service simply cannot be fulfilled.

9 The demand for care is great on the South Side  
10 and our response must be a bold one.

11 As we look to expand our clinical programs, we  
12 see a growing demand for inpatient admissions. Growth in  
13 specialty services, including cardiology, cardiac  
14 surgery, orthopedics, and cancer care have ranged from 8  
15 percent to 14.9 percent, and data indicates these growth  
16 trends will continue, if not accelerate, going forward.

17 Our emergency department today is one of the  
18 busiest in Chicago with more than 57,000 emergency room  
19 visits. ED visits have increased 6.5 percent annually,  
20 and we project the rate of increase to continue through  
21 2021.

22 As Dr. Druelinger had mentioned earlier today,  
23 approximately 24 percent of all emergency department  
24 visits result in an inpatient admission.

1           Additionally, we have committed to establish an  
2   Adult Level I trauma center. Our medical center campus  
3   is near some of the highest incidents of gun violence in  
4   the city. The number of shootings is up 66 percent from  
5   2015, and police confirm that violence is concentrated on  
6   the City's south and west side. This past weekend was a  
7   particularly grim weekend with 46 shootings.

8           The importance of this trauma center cannot be  
9   overstated. For years, South Side residents have been  
10  greatly -- and to be frank -- understandably upset about  
11  the lack of Level I trauma in their community. There is  
12  a desperate need for trauma services on the South Side.

13           Beds are needed to accommodate the projected  
14  growth in specialty care and ensure access for expansion  
15  of emergency and trauma services. We also know that beds  
16  are critical to reducing emergency department bypass  
17  hours. Our need to go on bypass is almost wholly  
18  attributable to bed constraints.

19           When I mentioned last Thursday, with that  
20  capacity constraint, we were on bypass for a total of 42  
21  hours. 42 hours we were closed to the community to  
22  provide services. We do not want high rates of bypass  
23  limiting access and prohibiting us from caring for  
24  patients seeking emergency care or, in the future, Level

1 I trauma services. An emergency department on bypass  
2 offers no trauma services.

3 As you heard earlier today, we have positive  
4 findings on almost all criteria in the state agency  
5 report. We believe the care we provide, our role on the  
6 South Side health care delivery system, and our  
7 commitment to expanding trauma services justifies an  
8 exception to the technical standards regarding historic  
9 utilization and construction costs.

10 We've documented that we will meet state  
11 requirements for utilization by the second year of  
12 operation. Our bed request is reasonable, and in view of  
13 the growth projections, is actually quite conservative.  
14 It is justified by our historical growth trends, our role  
15 as a regional resource in the advent of trauma care  
16 services.

17 We acknowledge that the costs of our project is  
18 higher than the state standard, but the SPR does an  
19 excellent job of laying out the unique circumstances of  
20 our redevelopment project. We would be happy to address  
21 any further questions you may have in this area.

22 We also recognize the Health Facility Planning  
23 Board's interest in preventing duplication of services so  
24 that there is not a negative impact on other providers in

1 the planning area. In fact, the opposite is true here.  
2 We are grateful for the overwhelming support received  
3 from our neighboring hospitals. You heard this morning  
4 from the leaders of South Shore Hospital, St. Bernard  
5 Hospital, and Roseland Hospital, who traveled here to  
6 personally express their support of the plan and who  
7 shared stories of their patients who are unable to Get  
8 CARE at the medical center when they needed it most.

9 We also received letters of support from  
10 La Rabida Children's Hospital, Loretto Hospital, Jackson  
11 Park Hospital, and the Roseland Medical District  
12 Commission.

13 Our project will better integrate any assets of  
14 the medical center with the assets of the local community  
15 hospital to offer a more coordinated health care delivery  
16 system with each institution playing an important and  
17 distinct role.

18 This project has no opposition. In fact, I  
19 would say the CON process here has unified our local  
20 South Side community around the common aim. We've worked  
21 hand-in-hand over the past years to develop this plan  
22 with our community and for our community. We ask your  
23 continued support of our South Side community and its  
24 need for essential medical services through your approval

1 of this plan.

2 We'd be happy to respond to any questions or  
3 comments you may have.

4 CHAIRWOMAN OLSON: Thank you. Questions from  
5 Board members? Mr. Sewell?

6 MEMBER SEWELL: Yes. Thank you, President  
7 O'Keefe. Okay. I've just never had this kind of problem  
8 before.

9 I want you to educate us a little bit about the  
10 trauma system. Now, when the University of Chicago  
11 Hospital was in the system before, were you in Region 11,  
12 or do you know?

13 MS. O'KEEFE: I was not here in 1988.

14 MEMBER SEWELL: Yeah. I guess I am going back.

15 Well, the reason I wanted to know, what I hear,  
16 I live on the South Side, and what I hear from people is  
17 that, you know, if a Level I trauma injury occurred on  
18 the South Side, they'd be taken to Christ Hospital in Oak  
19 Lawn, but it's not in Region 11.

20 MS. O'KEEFE: Correct.

21 MEMBER SEWELL: It's in a different region,  
22 right?

23 MS. O'KEEFE: It is, yes.

24 MEMBER SEWELL: But is the street version of

1 that, is that correct?

2 MS. O'KEEFE: Well, in Region 11, Dr. Doug  
3 Dirschl is here, so I could have him answer that. But at  
4 the high level, you know, some would argue there are the  
5 right number of trauma centers in the City of Chicago.  
6 The challenge that we have when you look at the South  
7 Side of Chicago, there simply is a big gap in the  
8 delivery system and there's a maldistribution, but let me  
9 ask Dr. Dirschl.

10 (Applause.)

11 DR. DIRSCHL: Thank you. I'm Doug Dirschl.

12 Yes, Region 11 -- Region 11 Trauma Medical  
13 Directors Committee, which I've been to a number of their  
14 meetings since we've been engaged in this, includes  
15 Advocate Christ Medical Center, even though for planning  
16 purposes in the state regions, that's not the City of  
17 Chicago. It includes that because we've worked so  
18 closely and intimately together.

19 When you look at transport patterns for  
20 patients who live on the South Side and for trauma  
21 activations, they actually don't go exclusively or even  
22 routinely west to Advocate Christ if they occur in the  
23 far south or even, you know, out in Naperville. They  
24 often, because of road traffic patterns, will head north,

1 and many of those go to Northwestern and many go to  
2 Stroger.

3 What I can tell you, also, we work closely with  
4 Region 11 medical directors. They have been very  
5 helpful, very supportive, in general, and we look forward  
6 to working with them more and being part of their system.

7 Everyone generally agrees, and I think as Gary  
8 Balady plainly has said publicly, having another trauma  
9 center on the South Side is a big win for the community  
10 of Chicago.

11 MEMBER SEWELL: Thank you.

12 There's another area where I need to be  
13 educated and it has to do with pediatric trauma. What's  
14 the situation right now for pediatric patients?

15 MS. O'KEEFE: Well, right now, in Region 11,  
16 there are two pediatric Level I trauma centers, one at  
17 Comer Children's Hospital, which is on our campus, and  
18 the other is at Lurie, associated with Northwestern; and  
19 Stroger.

20 DR. DIRSCHL: Stroger is not for children.

21 MS. O'KEEFE: It's not for children. Okay.

22 MEMBER SEWELL: Okay. Here's the distance  
23 between your proposal and the State agency report. I  
24 think it's with respect to medical/surgical beds, it's

1 163 beds difference, and with respect to the ICU beds,  
2 there's five beds difference.

3 Now, I was looking at your application, and  
4 first of all, I don't like demand-based formula because I  
5 think the issue is need, but need formula looks to  
6 subject to people arguing with each other about it, so we  
7 continue to use these demand-based formulas based on  
8 little other than use rates and population projections  
9 and those kind of things. But here's some things you  
10 said in your application that I think sort of explain the  
11 gap between what you're proposing and what the state  
12 agency rules are like.

13 First of all, your growth rate in terms of  
14 what's forecasted, the rate -- you've sort of proven  
15 correct with your growth rate because you have a 6.7  
16 percent annual growth and that's actual. That's sort of  
17 played itself out. I think what was forecasted back in  
18 2008 was 1.2 percent growth rate, so that's just for  
19 medical/surgical beds. The ICU was a little closer, but  
20 it was a 1.4 percent annual growth rate.

21 The occupancy back in 2014 was about 89  
22 percent. That's what's in your application, right? The  
23 actual in 2015 was 94 percent.

24 You also appeared -- and you can correct me if

1 I'm wrong -- to have predicated your need for beds on the  
2 possibility of some closures in your area. You talked  
3 about the closure of hospital facilities. I mean, there  
4 has been a historic trend, but it sounds like perhaps in  
5 your planning, you may think that that's not over. Now,  
6 you may not have named names, but there's always a  
7 contingency that that could happen.

8 You've got your emergency department visit  
9 growth at like 69 percent, and I think that's actual, and  
10 then finally there's the cancer care.

11 I guess I'd like you to address all these  
12 things you've said, which I'm not doubting, and how they  
13 speak to this gap between our rules and what you propose.  
14 You've got a 163 bed gap of medical/surgical and a five  
15 bed gap for ICU, and if I've left out any of the factors  
16 that you've considered, you can add those in your  
17 response, too.

18 MS. O'KEEFE: Yeah. I think -- I mean, it is a  
19 large request for beds, but I would go back to just what  
20 I've talked about over the last week.

21 We start out the day with literally a request  
22 or a need for 50 percent of those before we take a  
23 forward look around our growth going forward, and we have  
24 continued to grow at 6.7 percent per year. We continue

1 to anticipate our growth at about 6.5 percent and about  
2 1.2 percent in intensive care days. So what's driving  
3 that? Why do we believe that's going to continue?

4 A number of things that have occurred within  
5 the medical center that are drivers of our volume of  
6 growth are expansion of highly specialized services that  
7 only an academic medical center could provide. We are  
8 the only academic medical center on the South Side of  
9 Chicago, and through recruitment of faculty members and  
10 cardiovascular surgery, heart failure, cancer, offering  
11 bone marrow transplants, electrophysiology interventions,  
12 we have attracted a regional base of patients, and those  
13 specialized services are something that we believe are  
14 unique to an academic medical center.

15 We also have advanced diagnostic capabilities  
16 and interventional capabilities, whether those are  
17 neurointerventional services for the stroke patients or  
18 advanced diagnostics, such as PET scanning.

19 A couple of the other things that have driven  
20 our increases over the past couple of years is the growth  
21 of the emergency department, and for a period of time  
22 after the Board had granted us 38 additional beds, we  
23 actually drove down our diversion rate, our bypass rate,  
24 to six percent from what was around 20 percent. That

1 filled our beds when we were granted 38 more beds. That  
2 bypass rate has now crept up again because we are at our  
3 bed constraint, and when we look forward with an extended  
4 emergency department and continuing to admit 25 percent  
5 of all the patients we see, that's going to drive  
6 incremental volume to our inpatient bed base, and we are  
7 also looking to reduce the "left without being seen"  
8 rate.

9 You heard earlier this morning from  
10 Dr. Druelinger, this past year 5,000 patients left our  
11 emergency department due to long waits and their  
12 inability to be seen within a constrained emergency  
13 department. That's going to add more volume going  
14 forward.

15 All of those -- well, one other thing that you  
16 did mention is our interhospital transfer rates. We  
17 serve as a community resource to all community hospitals  
18 for patients who need a higher level of care. From 2014  
19 to 2015, the rate of transfers increased 13.5 percent.  
20 These are very sick patients. When we look at the length  
21 of stay of our -- what I would call our core business of  
22 the patients we admit, it 's about six days. When we  
23 look at the transfer patients that come in, their average  
24 length of stay is about ten days. So when you begin to

1 roll forward, all of those in a forward-looking planning  
2 mode, it is not difficult to get to the 168 incremental  
3 beds. The demand is there and we need to get ourselves  
4 out of these small step functions of adding a few more  
5 beds, filling them up, coming back, adding a few more.  
6 It is constraining our ability to serve our South Side  
7 community, and we need also to accommodate peak census  
8 once we open the trauma center.

9 Trauma is a random event. It doesn't occur in  
10 an elective manner. It's not a smooth flow of patients.  
11 It will have peaks and valleys, and we need to ensure  
12 that we have a sufficient bed base to allow us to respond  
13 to the peaks of demand within our community and the  
14 growth going forward.

15 (Applause.)

16 So I am very confident that this puts us in a  
17 position to require the number of beds we have in  
18 question.

19 MEMBER SEWELL: One final question. It appears  
20 that in the State agency report that you accept the  
21 Applicant's explanation as to why the construction costs  
22 exceed the standard, and it's that the project is sort of  
23 treated like new construction because many of these  
24 elements we don't have standards for, but some of them

1 that we do, appear to be within -- but overall, that's  
2 why the negative findings on that.

3 MR. CONSTANTINO: That's correct, yes. We  
4 considered that. We considered the project a substantial  
5 change in scope with the number of beds that had been  
6 requested, and when it was a substantial change in scope,  
7 we considered that new construction, not modernization.  
8 That's how our rules are defined.

9 MS. O'KEEFE: I want to make one other comment,  
10 because you had mentioned closure of other hospitals. I  
11 failed to address that.

12 Our application does not consider any closures  
13 of other hospitals on the South Side. When you look  
14 retrospectively over the last 25 years, close to 54  
15 percent of the beds on the South Side of Chicago have  
16 closed. Over 3,000 beds have been taken out of  
17 commission, and interestingly enough, adding these beds  
18 back to the University of Chicago Medical Center takes us  
19 back to about the same bed base we operated in the late  
20 1970s. So we're essentially restoring capacity to the  
21 medical center campus. It is not kind of replacing the  
22 lost capacity, but it is restoring the size of the  
23 medical center to what we were in our past history.

24 CHAIRWOMAN OLSON: Questions?

1 MEMBER MCGLASSON: Actually, I was about to ask  
2 that question you just answered.

3 CHAIRWOMAN OLSON: Doctor?  
4 Justice Greiman?

5 MEMBER GREIMAN: Yeah. I wondered -- you know,  
6 we heard this wonderful movement that's occurring on the  
7 South Side of Chicago. We've heard these wonderful  
8 things that are going to occur on the South Side of  
9 Chicago and the need for it and the glory of it and the  
10 beauty of it, but the question is, why isn't it going to  
11 be finished before 2022?

12 MS. O'KEEFE: Well, there's a couple of  
13 different phases.

14 MEMBER GREIMAN: I mean, that's six years, you  
15 know.

16 MS. O'KEEFE: It's kind of the operation of our  
17 cancer center. There's a couple of different phases that  
18 will come online here.

19 So our emergency department, we are estimating  
20 the construction of our emergency department to be  
21 completed in December of 2017. We would want to get into  
22 the emergency department, operate for a month or two,  
23 then we will stand up a Level I adult level trauma center  
24 within that.

1 Simultaneously, we'll be constructing or doing  
2 the construction in the Mitchell Hospital. It's a  
3 complicated project. That project will take us four  
4 years. It has to be phased because we will continue to  
5 take care of patients within that facility, so we  
6 anticipate the construction will be done in four years  
7 and then achieving the state standards for occupancy by  
8 the year 2022.

9 MEMBER GREIMAN: Okay. Thank you.

10 CHAIRWOMAN OLSON: Doctor?

11 EX OFFICIO MEMBER GOYAL: Thank you for -- I'm  
12 sure you can hear me now. Thank you for that recitation,  
13 Ms. O'Keefe.

14 I want to make a couple of comments. One,  
15 thank you for taking care of Medicaid. I represent  
16 Medicaid on this Board as an ex officio.

17 MS. O'KEEFE: We are the largest  
18 nongovernmental provider of Medicaid services in the  
19 State of Illinois.

20 EX OFFICIO MEMBER GOYAL: Yes. And I  
21 understand that Comer numbers may be even higher.

22 MS. O'KEEFE: That is correct.

23 EX OFFICIO MEMBER GOYAL: Right.

24 So the second comment I wanted to make is that,

1 even though you're expanding your capacity in different  
2 ways, I find it absolutely gratifying the community  
3 support that you've developed, the hospital support  
4 you've developed. It's almost not usual for us to see  
5 that. This is great.

6 (Applause.)

7 The third comment I wanted to make is that in  
8 today's time and age where payments are being received by  
9 institutions like yourself more on value as opposed to  
10 fee for service, the emergency room expenses may  
11 sometimes not be covered at all, and trauma care is  
12 really, really expensive, so if I had a vote on this  
13 Board, I would say to you that it is okay -- my personal  
14 understanding of the situation -- that you want to cover  
15 the bases to make sure that (a) your services are good  
16 for the community that you want to serve; (b) that your  
17 expenses will not put you under water. So I understand  
18 that, okay?

19 So having said that, I wanted to come back to  
20 the question that Judge Greiman asked you, which is, is  
21 it possible -- your community needed a Level I trauma  
22 center yesterday.

23 (Applause.)

24 But is it possible for you to incrementally

1 make it happen a lot quicker than two years, or four  
2 years, or six years?

3 (Applause.)

4 MS. O'KEEFE: I want to actually be real clear  
5 as to when trauma will come online versus when we will  
6 complete the cancer hospital.

7 We anticipate having adult Level I trauma  
8 services available in the first quarter, January or  
9 February, of 2018. So that is a much shorter period of  
10 time than two years, four years, or six years out.

11 The difficulty in providing those services any  
12 sooner are of the facilities and then a staffing issue.  
13 Our current emergency department simply cannot  
14 accommodate Level I adult trauma. It's undersized as it  
15 is right now and the absence of trauma resuscitation base  
16 is not there, so we must construct and build our new  
17 emergency department.

18 The second is, trauma services require highly  
19 specialized personnel, and the length of time to recruit  
20 those individuals, and I'll actually ask Dr. Dirschl to  
21 comment on the extensive team of specialized individuals  
22 that are needed for trauma services and how long that's  
23 going to take to recruit.

24 DR. DIRSCHL: Thank you.

1 First of all, let's kind of understand how  
2 important this is to the City of Chicago in that we  
3 estimate that when we open this new trauma center, in  
4 that first year, we may see 2,700 trauma patients in that  
5 year, which would make us in that first year the busiest  
6 trauma center in Chicago by far, and this is not  
7 something that once we say the doors are open, we can  
8 sail very readily, right? Injuries occur. We'll want to  
9 take care of them. EMS, Chicago Fire will want to bring  
10 them in. It could be both a very difficult thing for the  
11 community, as I say, but particularly I would have  
12 concerns that until and unless we are ready to accept the  
13 volume that we want to and we'll need to accept, quality  
14 of care, quality of individual patient care, could be  
15 compromised in some situations. So we need to be  
16 cautious about how we approach that.

17 And to Sharon's point about recruitment of  
18 specialists, there aren't very many trauma trained people  
19 like me currently on faculty at the University of Chicago  
20 because that hasn't been our core business for quite some  
21 time. We need to recruit these individuals. We have  
22 already begun the recruitment process for the chief of a  
23 new section of trauma and critical care surgery in our  
24 department of surgery, and I can tell you, the Applicant

1 pool -- I'm on that committee -- the Applicant pool has  
2 been outstanding, and the national buzz about this  
3 opportunity is amazing. People are seeing this as maybe  
4 one of the best trauma -- academic trauma leadership  
5 opportunities in the nation.

6 We'll get that recruitment in place and that  
7 individual will then recruit his or her faculty into that  
8 section. That individual will also begin immediately to  
9 engage with the community, as many of us have already.  
10 We'll be adding a couple -- probably a couple of  
11 orthopedic surgeons. We'll be adding others in  
12 neurosurgery and then a whole bunch of staff.

13 Remember, our staff needs training in trauma,  
14 too. Our nurses, our technicians, they all need that  
15 training, too.

16 So as much as I personally would love to open  
17 the doors right away, when we think about what's truly  
18 best for each patient and the quality of overall care, we  
19 need to take this a little more slowly.

20 So I apologize for that, but I mean it. I mean  
21 it in a way that this is so that every patient, every  
22 injured patient can get the best quality of care and the  
23 kind of care that I personally would be proud to deliver.

24 CHAIRWOMAN OLSON: Other questions?

1           Seeing none, I would ask for a roll call vote.

2           MR. ROATE: Thank you, Madam Chair.

3           Motion made by Mr. Sewell, seconded by Senator  
4 Burzynski.

5           Senator Burzynski?

6           MEMBER BURZYNSKI: Thank you. Based on the  
7 lack of opposition -- in fact, based upon the numerous  
8 people who have supported this project, including  
9 competitors in the area, I vote a resounding aye.

10          MR. ROATE: Senator Demuzio?

11          MEMBER DEMUZIO: Well, I believe the criteria  
12 questions have been answered today and from our Board,  
13 and I really appreciate the response coming from all of  
14 those that have been here today. It shows the need in  
15 your community, and I think it best sums it up by a  
16 gentleman who spoke earlier. It's kind of sad when  
17 someone says, "Your medical care should not feel like a  
18 lottery," and I think that sums it up, so I'm voting aye.

19          MR. ROATE: Thank you.

20          Mr. Galassie.

21          MEMBER GALASSIE: It's a bold plan and I  
22 congratulate you for it. The needs that exist are just  
23 deplorable and our overall system from a 30-year public  
24 health career, this is one of the most wonderful things

1 I've heard for the South Side of the City of Chicago. So  
2 yes, I vote yes.

3 MR. ROATE: Thank you.

4 Justice Greiman.

5 MEMBER GREIMAN: I had planned to make a  
6 dramatic, gracious speech in casting my vote, but when I  
7 noted that of the eight hospitals in Area A-03, five of  
8 them have come forward asking that this be approved,  
9 minus the otherwise, I vote aye.

10 (Applause.)

11 MR. ROATE: Thank you.

12 Mr. Hayes.

13 VICE CHAIRMAN HAYES: I'm going to vote yes  
14 based on many of the comments that have been previously  
15 expressed.

16 (Applause.)

17 MR. ROATE: Thank you.

18 Mr. Johnson.

19 MEMBER JOHNSON: As a lifelong resident of Hyde  
20 Park and South Shore, I was going to ask, What took so  
21 long?

22 (Applause.)

23 But I didn't, so I'm going to vote yes.

24 (Applause.)

1 MR. ROATE: Mr. McGlasson.

2 MEMBER MCGLASSON: Yes, for previous comments.

3 (Applause.)

4 MR. ROATE: Mr. Sewell.

5 MEMBER SEWELL: When Salim Al Nurradin  
6 testified, he talked about a new beginning in terms of  
7 the relationship between the University of Chicago and  
8 the community, and it's very rare to see competing  
9 hospitals support such an extraordinary program like  
10 this.

11 I think for those things that are stated in the  
12 report that we talked about, I think a good case was made  
13 with the gap between what the Applicant is proposing and  
14 what our rules allow for, and I also think that the State  
15 agency report accepts the cost issue that caused you to  
16 not get a yes on the reasonableness of the project costs,  
17 so I vote yes.

18 (Applause.)

19 MR. ROATE: Madam Chair?

20 CHAIRWOMAN OLSON: I'm not sure that we've ever  
21 seen a project, as long as I've been on this Board, where  
22 the need has been demonstrated quite so well. I'm going  
23 to make it a unanimous one hundred percent yes.

24 (Applause.)

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MS. O'KEEFE: Madam Chair and the Board  
Members, on behalf of the entire community and the  
patients that we'll be honored to serve, thank you very  
much.

(Applause.)

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CHAIRWOMAN OLSON: Next, we will call 16-009, DaVita Collinsville Dialysis. Will the Applicants please come to the table?

I need quiet in the room, please. We still have business to conduct, please.

May I have a motion to approve Project 16-009, Davita Collinsville Dialysis, to establish an eight-station ESRD?

MEMBER GALASSIE: So move.

VICE CHAIRMAN HAYES: Second.

CHAIRWOMAN OLSON: I also need to have the record reflect that Mr. Johnson had to leave.

Will the Applicant be sworn in, please?

(Six witnesses sworn.)

CHAIRWOMAN OLSON: Your report, Mr. Constantino?

MR. CONSTANTINO: Thank you, Madam Chairwoman.

The Applicant's proposing to establish an eight-station ESRD facility in Collinsville, Illinois, at a cost of approximately 2.4 million dollars and an anticipated completion date of November of 2017.

Currently, there's an excess of 11 stations in this planning area. There was no public hearing, and no

1 letters of support or opposition were received by the  
2 Board Staff.

3 We had findings related to planning area need  
4 and an unnecessary duplication of service.

5 Thank you, Madam Chairwoman.

6 CHAIRWOMAN OLSON: Thank you, Mike.

7 Comments for the Board.

8 MS. DAVIS: Thank you very much. My name is  
9 Penny Davis, and I'm the Division Vice President for  
10 DaVita. With me at the table is Mary Anderson, another  
11 Division Vice President here in Illinois, Dr. Tim  
12 Kanungo, the proposed management director for the  
13 project, Jill Abernathy, the facility administrator for  
14 Maryville Dialysis, and, of course, Chuck Sheets and Anne  
15 Cooper from Polsinelli, our CON attorneys.

16 First of all, I don't know how to follow that  
17 last project, but as a former trauma nurse, thank you.  
18 Great job. They were amazing.

19 So the project that we bring before you today  
20 is for a facility in Collinsville, Illinois. It's  
21 HSA-11, and for the past four years, from calendar year  
22 2012 through 2015, the annual countdown-based increase in  
23 end stage renal disease in this HSA is actually 36  
24 percent higher than it is in the rest of the State of

1 Illinois.

2 In the health reform, we truly expected that  
3 number is going to go up even more. We have seen more  
4 and more patients identified with CKD, which is chronic  
5 kidney disease, which leads then to end stage renal  
6 disease, due to greater access to health care through the  
7 ACA and Medicaid expansion.

8 The proposed project and the recently approved  
9 projects in Belleville and O'Fallon will serve distinct  
10 issue populations. Collinsville will specifically and  
11 primarily serve Dr. Kanungo's patient base. He is  
12 currently treating 122 patients that are stage 3, 4 and 5  
13 ESRD, and we anticipate 42 of those patients will start  
14 dialysis in the next two years.

15 As you might recall, an eight-station facility  
16 would run six shifts a week at maximum. That would mean  
17 that they could only care for 48 patients. So by saying  
18 that we're expecting 42, within two years that really  
19 will be above the 80 percent mark.

20 The Belleville facility that was approved  
21 several months ago is a different physician -- that's  
22 Dr. Koch -- and he has 364 patients and he anticipates 72  
23 percent of those patients will treat at Belleville. On  
24 the 72 patients, Belleville is projected to operate at a

1 hundred percent capacity within its second year.

2 O'Fallon Dialysis will primarily take care of  
3 Dr. Dalal's patient base. He's treating over 600  
4 patients that are stage 3, 4 and 5, and he anticipates up  
5 to 60 percent of those patients will start at Belleville  
6 within two years prior to completion. By year two of  
7 operation in O'Fallon, they're expected to be at 82  
8 percent above the state standard.

9 There is no significant overlap with the  
10 patients on these different physicians.

11 As noted in our application, the existing  
12 facilities in the service area are highly utilized.  
13 Excluding the recently improved FMC Belleville and  
14 O'Fallon dialysis facilities and the expansion that was  
15 approved in February, all of which are not online, the  
16 average utilization of facilities per our report was at  
17 79.8. As of today, it's currently 80.9. So those  
18 facilities' utilization has grown. Between December 31st  
19 and today, these facilities have increased by two  
20 percent, between two and nine percent. So, like I said,  
21 the growth in the dialysis patients is huge.

22 We believe that there are significant patient  
23 numbers that support the project. Maryville, which  
24 there's only five facilities there in the same county

1 with Collinsville, and because of transportation issues,  
2 patients can't transfer across county lines. We do have  
3 situations where it would be possible that if they live  
4 in the other county, they could be dropped off by the bus  
5 or a transit bus at the Hardee's restaurant and then  
6 picked up by the other county's transport to be taken to  
7 dialysis facilities. So we're trying to keep facilities  
8 within the communities in which people live.

9 So only five facilities are in Madison County  
10 in that area. Two are over 20 minutes away and the other  
11 three are operating above 70 percent. Based on the  
12 growth in that community, we expect them to hit 80  
13 percent very quickly.

14 I would go into talking about DaVita's  
15 qualities, but I've talked about that ad nauseam at these  
16 meetings, that we are number one in terms of CMS ratings  
17 and QIP ratings.

18 In Illinois, over 50 percent of our facilities  
19 are ranked four- and five-star, which is more than three  
20 times the competition, and at the same time, we are the  
21 smaller provider within Illinois, like the smaller market  
22 share.

23 So, with that, I will take any questions you  
24 might have.

1 CHAIRWOMAN OLSON: Questions from Board  
2 Members?

3 Mr. Sewell.

4 MEMBER SEWELL: Thank you, Madam Chairman.

5 Help me with my argument in support of what  
6 appears to be an additional eight stations in the  
7 planning area that has 11 excess, and then in the  
8 inventory, you've got these two new players that haven't  
9 come online yet, but they are counted in the inventory  
10 with, I believe, 12 -- yeah, 12 stations each.

11 It's a tough question, but I want to hear the  
12 argument.

13 MS. DAVIS: Okay. Hopefully, I can help you  
14 with that.

15 So when we do these application, we identify --  
16 we work with the physicians to get their patient lists of  
17 patients who are CKD 3, 4 and 5. We never duplicate. We  
18 make sure that that patient is truly assigned to that  
19 physician, is not counted in any other application with  
20 any other physician.

21 So each of these applications stands on their  
22 own, based on the physician seeking D-data that was  
23 utilized to develop those applications. There really is  
24 this number of CKDs in that community, and we can only

1 assume -- and I know that I've heard other providers  
2 assume on their percent -- we only assume that 80 percent  
3 of stage 5 will need dialysis within two years. We need  
4 60 percent of stage 4. So, you know, we're making sure  
5 that we're not trying to over count. And then stage 3  
6 CKD, we only expect 20 percent of those to move to end  
7 stage renal disease.

8 So even though the station need is what it is,  
9 the patients, the specific patients assigned to those  
10 doctors and using their diagnosis, you know that a  
11 physician is certifying they are at that level.

12 MEMBER SEWELL: Okay. So is this somehow a  
13 byproduct of this phenomenon where, first of all, we've  
14 got the increase in aging population and we've got this  
15 chronic disease phenomenon, which is a much higher  
16 penetration.

17 Is that how you would -- but when you do the  
18 stages, you're arguing that you get a different kind of  
19 projection of what's needed out there than just doing the  
20 demand for it. Is that what you're saying? Because  
21 that's what I'm thinking in my head. I want to make sure  
22 I'm right.

23 MS. DAVIS: Right, because it's based on the  
24 progression of the disease. So someone who has kidney

1 function by lab test shows that they may be CKD 3, we may  
2 be able to help prevent them from going all the way to  
3 end stage renal disease.

4 Somebody's who's stage 5, you know, they're  
5 already very, very far progressed, so we're saying 80  
6 percent of those patients will have to go on dialysis.

7 You know, it's -- we have over a million  
8 patients in Illinois with CKD, and a majority of them  
9 don't even know they have chronic kidney disease.

10 We will go to different events. We're doing a  
11 screening event up in Waukegan, for instance, the end of  
12 this month, and we'll do CKD screenings, and we will find  
13 hundreds of patients. It's amazing to me.

14 We do Mattie Hunter's events and we do  
15 back-to-school events on the South Side, and, you know,  
16 we're talking a hundred patients that we will identify  
17 that never knew they had kidney disease, because it  
18 really is a silent killer.

19 VICE CHAIRMAN HAYES: Yeah. I'd like to break  
20 in now and acknowledge that Kathy Olson has left for the  
21 day, and so I'll be taking over as Chairman.

22 MS. DAVIS: Thank you.

23 MEMBER MCGLASSON: Mr. Chairman.

24 One simple question. Do you receive government

1 funds of any kind beyond the fees for services?

2 MS. DAVIS: All of dialysis is covered under a  
3 special portion of Medicare, the end stage renal disease.  
4 Over 90 percent of our funding or revenue is from  
5 government programs, Medicare and Medicaid. In fact, of  
6 those two programs, payments do not cover the cost of  
7 dialysis.

8 VICE CHAIRMAN HAYES: Senator Demuzio.

9 MEMBER DEMUZIO: Penny, I have a question.

10 Okay. Going south, okay, I see Collinsville.

11 Are you in Litchfield also? Are you? Okay.

12 MS. DAVIS: Yes.

13 MEMBER DEMUZIO: Okay. So we go from  
14 Litchfield out of Springfield, Illinois. I'm trying to  
15 take it south. Where else besides Collinsville?

16 MR. SHEETS: Edwardsville.

17 MEMBER DEMUZIO: Yeah. You're going from  
18 Litchfield out of Springfield -- well, there's nothing  
19 between Springfield and Litchfield. Well, Alton. Okay.

20 MS. DAVIS: There's Edwardsville, O'Fallon,  
21 Shiloh, Granite City, and Maryville.

22 MEMBER DEMUZIO: Okay. And that's your pool  
23 that you're pulling from, is that correct?

24 MR. SHEETS: Those are all the DaVita

1 facilities.

2 MS. DAVIS: Those are all the DaVita  
3 facilities.

4 MEMBER DEMUZIO: And Litchfield, I believe, you  
5 pulled out of Carlinville, Staunton, all that whole  
6 central area there.

7 Okay. I was just curious.

8 VICE CHAIRMAN HAYES: Judge Greiman.

9 MEMBER GREIMAN: I notice that you have about  
10 12 or 13 projects, and about 10 of which have ending  
11 dates or theoretical ending dates in '17. You set up  
12 2017 as the closing date for this one. Is that  
13 realistic? That's a big volume.

14 MS. DAVIS: Yeah. This is the existing  
15 building that we're going to retrofit for dialysis. If  
16 it's a ground up, we, you know, have to -- that takes a  
17 lot longer, but this is an existing building that we're  
18 able to rehab and develop the dialysis there.

19 MEMBER GREIMAN: So it's realistic, you think.

20 MS. DAVIS: Yes.

21 VICE CHAIRMAN HAYES: Does anyone on the Board  
22 have any other questions?

23 Seeing none, George, can you have a roll call?

24 MR. ROATE: Thank you, Chairman.

1 Motion made by Mr. Galassie; seconded by  
2 Chairman Hayes.

3 Senator Burzynski.

4 MEMBER BURZYNSKI: Based on the explanations  
5 and the questions that we've had here today, I vote yes.

6 MR. ROATE: Thank you.

7 Senator Demuzio.

8 MEMBER DEMUZIO: I vote yes, due to the fact  
9 that I think most of our questions have been answered.  
10 Thank you.

11 MR. ROATE: Thank you.

12 Mr. Galassie.

13 MEMBER GALASSIE: Yes, comments stated.

14 MR. ROATE: Thank you.

15 Justice Greiman.

16 MEMBER GREIMAN: Yes.

17 MR. ROATE: Chairman Hayes.

18 CHAIRMAN HAYES: Yes, based on the State agency  
19 report and the comments that were made that explained  
20 some of these, you know, criteria that were not met.

21 MR. ROATE: Thank you.

22 Mr. McGlasson.

23 MEMBER MCGLASSON: Yes, based on previous  
24 comments.

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MR. ROATE: Thank you.

Mr. Sewell.

MEMBER SEWELL: I'm going to pass on this. I don't know what to do.

MR. ROATE: Is that a negative, or are you just going to abstain?

MEMBER SEWELL: No, I'm going to abstain.

MR. ROATE: You're going to abstain. Okay. That's six votes in the affirmative; one vote on pass.

CHAIRMAN HAYES: The project has been approved. Thank you very much.

MS. DAVIS: Thank you.

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CHAIRMAN HAYES: The next project for us is  
H-06, Project 16-010, OSF St. Mary Medical Center.

May I have a motion to approve Project 16-010,  
OSF St. Mary Medical Center, to approve a  
modernization/expansion project.

MR. ROATE: Do we have a motion?

CHAIRMAN HAYES: A motion.

MEMBER BURZYNSKI: So move.

CHAIRMAN HAYES: I have a motion to approve the  
motion. I need a second.

MEMBER GALASSIE: Second.

CHAIRMAN HAYES: Thank you.

Mr. Constantino, should they be sworn in first?

(Two witnesses sworn.)

CHAIRMAN HAYES: Mr. Constantino, State agency  
report?

MR. CONSTANTINO: Thank you, Mr. Chairman.

The Applicant is proposing to modernize and  
expand key clinical areas on the campus of OSF St. Mary  
Hospital in Galesburg, Illinois. The anticipated project  
cost is approximately 28.1 million dollars. The  
anticipated completion date is August 15, 2019.

We had two findings related to this project.

1 One dealt with the size of the project for the PACU, and  
2 the second was regarding the reasonableness of project  
3 costs, modernization and proportionate contingencies  
4 costs, which the Applicants have addressed in a letter  
5 regarding the State Board staff report that I've put in  
6 front of you.

7 CHAIRMAN HAYES: Thank you.

8 The Applicant?

9 MS. CROSSER: Yes. Hello, and good afternoon,  
10 and thank you for letting us be here today. I'm Roxanne  
11 Crosser. I'm the President of OSF St. Mary Medical  
12 Center, and Curt Lipe, our Vice President and Chief  
13 Financial Officer, and I have a few left here in the back  
14 for support for this particular project.

15 First of all, thank you for an exciting day.  
16 It certainly has been interesting.

17 We're pleased to be here today to describe our  
18 project. We'll keep our comments short, mainly because  
19 it has been a long day and also because of the support  
20 that we've had with Mr. Constantino and Mr. Roate giving  
21 a lot of information in advance.

22 OSF St. Mary Medical Center is part of OSF  
23 Healthcare System. We've been part of that system for  
24 over a hundred years and have been on the present site

1 for a little over 40 years, and during that time, we have  
2 made investments on our ambulatory and growth on the  
3 outpatient side and a little bit of investments within  
4 the facility, but it truly is time within 40 years to  
5 make some -- a little bit more major investments.  
6 Obviously, health care has changed and really keeping up  
7 with the delivery of health care from the switch from  
8 inpatient to outpatient and the whole flow in many of  
9 these particular services.

10 So the departments that need the most changes  
11 or modernization is our surgery department,  
12 endoscopic-related recovery, our laboratory, cardiology  
13 services, some cardiac diagnostic services.

14 So the integration of this particular project,  
15 resolving many of the facility issues and the flow for  
16 our patients we feel are very, very important.

17 The overall project has a little bit under  
18 6,000 additional square feet, which has a couple floors  
19 involved, but it's mainly modernization of the present  
20 facility that we're in.

21 The report does show two findings from the  
22 State Board Report, and I've asked Mr. Curt Lipe to  
23 address those two concerns.

24 MR. LIPE: Is it on now? Thank you.

1           Mr. Chairman, thank you for this opportunity  
2 and thank you to all the Board Members for all the work  
3 you've done today.

4           I'm going to address the two findings  
5 Mr. Constantino has referenced.

6           I'll start with the square footage around the  
7 surgery bays, because we are at about 300 square feet per  
8 surgery bay, as opposed to the state guideline of 180  
9 feet. Since that guideline was adopted a number of years  
10 ago, there's been quite a bit of change around the type  
11 of care and who is involved in that care as it relates to  
12 recovery beds.

13           I would note that we are -- this project  
14 overall is decreasing our number of surgical suites, so  
15 we are also decreasing our recovery beds by a  
16 commensurate amount, while still meeting all the  
17 applicable IDPH requirements.

18           As we've indicated, part of this -- a  
19 significant portion of this project is around existing  
20 space, modernizing within existing space, and this is one  
21 of those spaces. So there's certain areas in there that  
22 there's not a whole lot we can do with or move, whether  
23 it be structural columns, mechanical shafts, egress  
24 stairs. So we're having to work around that a little

1 bit, which is increasing some of the square footage of  
2 the space allocated to the PACU area.

3 Also, we're accommodating family members,  
4 visitors, and loved ones into this. Recent provisions to  
5 the Illinois Hospital Licensing Code allows visitors in  
6 the recovery room space. If we're going to have visitors  
7 in the recovery room space, we're going to need to have  
8 someplace for them to be, so we're providing additional  
9 space for that as well, not to mention the complexity of  
10 the care that we provide.

11 There's so much more equipment today, whether  
12 it be ventilators, pumps, imaging equipment, and we need  
13 space for all of that type of equipment to be able to  
14 have caregivers to move easily around the patients.

15 And, of course, we're always aware and very  
16 cognizant of the need for patient privacy, and this  
17 project will greatly enhance the patient privacy that  
18 will be provided, along with allowing us to enhance and  
19 improve upon infection control, indeed infection  
20 prevention moving forward.

21 So when you consider the clinical operational  
22 and licensing considerations, I think that's what leads  
23 us to the square footage that we have included for the  
24 PACU area.

1           The second finding relates to the cost of the  
2 new construction and modernization. We have provided a  
3 fairly detailed listing to the staff, and I would be more  
4 than happy to go through whatever detail level of that  
5 you would like to go through today. I would say,  
6 however, that probably you can summarize this around two  
7 or three different types of activities. Number one,  
8 between the lab and particularly the surgical space,  
9 these are high-tech areas. They have a higher cost level  
10 associated with them to develop those, as opposed to  
11 storage or other less complex areas.

12           It's also a phased project. There's ten phases  
13 in this project that are going to stretch over a period  
14 of right around 30 months, about two and a half years,  
15 because obviously we're going to have to keep open  
16 everything we're currently doing while we're in the  
17 process of renovating and expanding. That creates some  
18 staffing inefficiencies, both for the hospital but also  
19 for the construction crews, and because of the phasing  
20 and infection control which goes along with that, we'll  
21 be building things for one area, then taking them down  
22 and building them someplace else for another area. So we  
23 anticipate that there's quite a bit of cost associated  
24 with that.

1           We do know that as it relates to the new  
2 construction piece, which as Roxanne indicated is about  
3 6,000 square feet, it's going to create some drainage  
4 issues for us, and so in order to prevent that, we had to  
5 include some additional costs around the new construction  
6 to keep that drainage away from the existing facility.

7           There's also a lot of infrastructure needs that  
8 are going into this project, both on the new construction  
9 and on the modernization piece.

10           We know, for example, that we're going to have  
11 to put in a new emergency power system to support the new  
12 area. Currently, we have a blended emergency power  
13 supply system, and that is not appropriate or acceptable  
14 to IDPH, so we will be upgrading our entire emergency  
15 power system, and that one piece in and of itself is not  
16 quite 1.3 million dollars.

17           We also know that there will be new dedicated  
18 air handlers to provide the required air handling for the  
19 surgical area and the dedicated supply.

20           We're going to put in a new fire pump to enable  
21 us to provide safe care for all those who come. A lot of  
22 HVAC costs related to the size of the ductwork that's  
23 coming into the building. So it's just a lot of  
24 infrastructure costs.

1           We also know that as we open up between the  
2 floors, we're going to have to fireproof the decks  
3 because built in 1974, we know they don't quite meet  
4 current standards, so we will be doing all of that  
5 fireproofing as we move along, and as we know, that can  
6 be a rather expensive endeavor as we've had to do some of  
7 that in the past.

8           We will have personnel doing fire watch during  
9 the construction process because not everything will be  
10 on the fire alarm system initially, so we will actually  
11 have staff patrolling those areas to ensure the safety of  
12 the occupants, and there will be a lot of off-hour type  
13 of costs that we have to do in order to keep our  
14 surgeries going and the other services as well.

15           So, as I said, I will be more than happy to  
16 look -- review with you all of the details of that, but  
17 we've identified about 3.4 million in costs related to  
18 the impediments for the modernization and about 780,000  
19 related to the new construction area, and that pretty  
20 much covers the excess costs that we are currently  
21 seeking in the project, and I believe we -- I know we've  
22 met the other ten criteria as laid out, and we would be  
23 happy to try and answer any questions anybody might have.

24           CHAIRMAN HAYES: Any questions from Board

1 Members?

2 MEMBER GALASSIE: No.

3 MEMBER GREIMAN: No.

4 MEMBER DEMUZIO: Just a quick question.

5 CHAIRMAN HAYES: Senator Demuzio?

6 MEMBER DEMUZIO: Just a quick question.

7 What's your service area? I noticed that there  
8 must be what, two hospitals in Galesburg?

9 MR. LIPE: Correct. There are two hospitals in  
10 Galesburg.

11 MEMBER DEMUZIO: And what is your service area?

12 MR. LIPE: Our primary service area is Knox,  
13 Warren and Henderson Counties. Our secondary service  
14 area extends into --

15 MS. CROSSER: Fulton, Henry, Stark Counties.  
16 So the primary service area is probably right around  
17 80,000, including secondary, about 135,000.

18 MEMBER DEMUZIO: So do you basically split up  
19 both of your populations? Because I know where  
20 Galesburg's at and I know that's going into what, east?  
21 Southern, east central, east?

22 MR. LIPE: It varies by service. I'm not going  
23 to pretend that my response to that will be totally  
24 unbiased. We do enjoy a fairly significant market share

1 in the market, in the surgery area in particular.

2 MEMBER DEMUZIO: Okay.

3 MR. LIPE: Sixty percent of surgeries that come  
4 into Cottage and St. Mary come to St. Mary Hospital.

5 MEMBER DEMUZIO: So by boosting your appearance  
6 and whatever, I think this is going to make a big  
7 difference in your population?

8 MR. LIPE: We're excited about what we're going  
9 to be able to do for our population.

10 You know, I can't pass up the opportunity to  
11 point out that we do provide care to anybody that comes  
12 our way: Charity care, Medicaid, it doesn't matter. So  
13 we're excited to be able to do that for everybody in our  
14 service area.

15 MEMBER DEMUZIO: That's good.

16 CHAIRMAN HAYES: Any more questions from Board  
17 Members?

18 George, may I have a roll call vote?

19 MR. ROATE: Yes, sir.

20 Motion made by Mr. Hayes; seconded by  
21 Mr. Galassie.

22 Senator Burzynski.

23 MEMBER BURZYNSKI: Based on the Applicant's  
24 response to the Staff's findings and lack of opposition,

1 I vote aye.

2 MR. ROATE: Thank you.

3 Senator Demuzio.

4 MEMBER DEMUZIO: And I am going to go with  
5 getting that area approved over there, right?

6 MR. ROATE: Thank you.

7 Mr. Galassie.

8 MEMBER GALASSIE: Aye for reasons stated.

9 MR. ROATE: Thank you.

10 Justice Greiman.

11 MEMBER GREIMAN: Aye for reasons stated.

12 MR. ROATE: Thank you.

13 Mr. McGlasson.

14 MEMBER MCGLASSON: Aye because of the reasons  
15 stated.

16 MR. ROATE: Thank you.

17 Mr. Sewell.

18 MEMBER SEWELL: I vote yes. I think that  
19 the -- during the Q and A, the concerns that were in the  
20 State agency report were addressed.

21 MR. ROATE: Chairman Hayes.

22 CHAIRMAN HAYES: Yes, because of the  
23 explanation for Board Member Sewell.

24 MR. ROATE: Seven votes in the affirmative.

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CHAIRMAN HAYES: Motion passes.

MS. CROSSER: Thank you very much.

CHAIRMAN HAYES: And you'll receive a letter  
from Mike.

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CHAIRMAN HAYES: Okay. Applications subsequent to intent to deny, there's none.

Other business, none.

Now, rules development. Jeannie, do you want to look at this, take this part?

MS. MITCHELL: Yes.

In the interest of time and so that I don't get killed on my way out of here, I will be as brief as I can.

First, there are three rules I want to assess and then I'll go back and complete.

The first is the 1130 Rules. They are operational rules. In your packet, you received a summary of the changes that we're going to make on second notice. We published them for first notice on December 28, 2015. We received responses from, or comments rather, from the IHA and HCCI, so we're making some changes in response to those comments, but we're also not making some of those changes on the request. So I prepared a memo discussing what we're doing and why.

So what I request is that I -- that you guys approve these to be published for second notice and that I have authority to discuss any future changes and submit

1 them to JCAR after the May 10th Board meeting.

2 CHAIRMAN HAYES: Okay. Are there any questions  
3 for Jeannie?

4 Hearing none, can I have a motion?

5 MEMBER SEWELL: So move.

6 MEMBER BURZYNSKI: Second.

7 CHAIRMAN HAYES: George, can I have a roll  
8 call?

9 MR. ROATE: Yes, sir.

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

12 Senator Burzynski.

13 MEMBER BURZYNSKI: Aye.

14 MR. ROATE: Senator Demuzio.

15 MEMBER DEMUZIO: Aye.

16 MR. ROATE: Mr. Galassie.

17 MEMBER GALASSIE: Aye.

18 MR. ROATE: Justice Greiman.

19 MEMBER GREIMAN: Aye.

20 MR. ROATE: Chairman Hayes.

21 CHAIRMAN HAYES: Yes.

22 MR. ROATE: Mr. McGlasson.

23 MEMBER MCGLASSON: Yes.

24 MR. ROATE: Mr. Sewell.

1 MEMBER SEWELL: We don't have to give a reason,  
2 do we?

3 MS. MITCHELL: No.

4 MEMBER SEWELL: Aye.

5 MR. ROATE: That's seven votes here.

6 CHAIRMAN HAYES: The motion passes.

7 MS. MITCHELL: Next up is the 1170 Rules. You  
8 did not receive this in your packet, but basically we're  
9 repealing these rules. We already discussed it when we  
10 submitted the first notice, but I want to go on to the  
11 second notice. These are the rules dealing with areawide  
12 health planning organizations. We don't use areawide  
13 health planning organizations and have not done so for  
14 over a decade, if not more.

15 So I simply request approval to repeal.

16 CHAIRMAN HAYES: All ayes, say aye.

17 (Ayes heard.)

18 Any other negative, like sign?

19 (No response.)

20 The motion now passes.

21 MS. MITCHELL: The 1250 rules are just like the  
22 1170 rules. This is an appropriateness review rule. We  
23 don't conduct this review because we don't have our  
24 areawide health organizations anymore, so we have already

1 submitted it for first notice and we want to submit it  
2 for second notice, so I simply need the approval to do  
3 so.

4 CHAIRMAN HAYES: Do you have -- all in favor,  
5 say aye.

6 (Ayes heard.)

7 Opposed, like sign.

8 (No response.)

9 The motion passes.

10 There's old business, none.

11 New business, the financial report and the  
12 legislative update.

13 Courtney, can you briefly address these two  
14 issues?

15 MS. AVERY: Yes.

16 You have in your packets the financial report  
17 that was prepared for us with more detail than was given  
18 to us, for expenditures to date -- no, I'm sorry, it's  
19 through March -- and one that was pointed out is the  
20 "contractual" line that jumped in the third quarter to  
21 \$99,571. I was told that it's that amount because in the  
22 contractual line, there are quite a few items that belong  
23 in that line, and those were not broken out, so that's  
24 why we see a big jump there, and then there were some

1 expenditures, so we don't really have like a \$60,000  
2 increase for that one quarter.

3 CHAIRMAN HAYES: Okay.

4 MR. DART: I had a correction. In looking at  
5 the financial report today, I see that on page 6, the  
6 revenue for the third quarter was unreported. It appears  
7 that only one month was captured. It's showing  
8 292,035.61 for the third quarter, and that number should  
9 be \$768,934.53.

10 MEMBER GALASSIE: All right.

11 MS. AVERY: Can you make the correction, and  
12 then I'll e-mail the corrected version to you all.

13 CHAIRMAN HAYES: Okay. That sounds fine.

14 MEMBER SEWELL: It sure does.

15 MEMBER GALASSIE: Mr. Chair, do we know, are we  
16 starting at 9:00 or 10:00 in Canton?

17 CHAIRMAN HAYES: 10 o'clock.

18 Okay. Any legislative updates?

19 MS. AVERY: Just real quick.

20 Our 4517 and 18 passed out of the Public Health  
21 Senate Committee unanimously on the agreed bill list.  
22 It's on the second reading now and we'll probably have it  
23 heard this week.

24 That's the most important ones, and I can send

1 you a sheet or something later on.

2 4517 is the repeal of a section on  
3 comprehensive health planning, which you didn't like, and  
4 4518 is the one that kind of cleans up some language  
5 within our Act. I'll send you the details.

6 CHAIRMAN HAYES: Okay. Thank you very much,  
7 Courtney.

8 The next meeting is June 21st at the  
9 Bolingbrook Country Club.

10 MS. AVERY: Golf club.

11 CHAIRMAN HAYES: Okay.

12 Can I have a motion to adjourn the meeting?

13 MEMBER GALASSIE: So move.

14 MEMBER SEWELL: Second.

15 CHAIRMAN HAYES: Can I have all in favor?

16 (Ayes heard.)

17 Negative, like sign.

18 (No response.)

19 Motion carried.

20 EX OFFICIO MEMBER GOYAL: On the schedule, on  
21 the agenda, it says June.

22 MS. AVERY: Did you have an updated agenda?

23 MS. MITCHELL: We'll tell you. We'll make sure  
24 you go to the right place.

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MR. ROATE: The updated agenda shows June.

MS. AVERY: It shows June. So look at the one right below, and then on the chart, that's the one that says August.

EX OFFICIO MEMBER GOYAL: Thank you.

CHAIRMAN HAYES: We're adjourned.

(Board meeting adjourned at 4:27 p.m.)

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CERTIFICATE OF SHORTHAND REPORTER

I, LISA HAHN PETERMAN, Certified Shorthand Reporter No. 084.002149 CSR, RMR, and a Notary Public, in and for the County of Macon, State of Illinois, the officer before whom the foregoing proceedings were taken, do hereby certify that the foregoing transcript is a true and correct transcript of the proceedings, that said proceedings were taken by me stenographically and thereafter reduced to typewriting under my supervision, and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 23rd day of May, 2016.

My commission expires October 7, 2017.

Lisa K Hahn 

Notary Public in and for the  
State of Illinois

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