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Transcript of Open Session- Meeting

Date: October 22, 2019

Case: State of Illinois Health Facilities and Services Review Board

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ILLINOIS DEPARTMENT OF PUBLIC HEALTH
HEALTH FACILITIES AND SERVICES REVIEW BOARD

OPEN SESSION - MEETING

Bolingbrook, Illinois 60490

Tuesday, October 22, 2019

9:06 a.m.

BOARD MEMBERS PRESENT:

RICHARD SEWELL, Acting Chairman

SANDRA MARTELL

LINDA RAY MURRAY

DEBRA SAVAGE

KENT SLATER

Job No. 223751B

Pages: 1 - 197

Reported by: Paula Quetsch, CSR, RPR

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1 EX OFFICIO MEMBERS PRESENT:

2 DAN JENKINS, Department of Healthcare and
3 Family Services

4 DULCE QUINTERO, Department of Human
5 Services

6

7 ALSO PRESENT:

8 COURTNEY AVERY, Administrator

9 JUNAID AFEEF, General Counsel

10 MICHAEL CONSTANTINO, IDPH Staff

11 ANN GUILD, Compliance Manager

12 GEORGE ROATE, IDPH Staff

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1 P R O C E E D I N G S

2 CHAIRMAN SEWELL: Let's settle ourselves
3 and I'll call the meeting to order. I hope
4 everyone that plans to participate in giving
5 testimony has registered outside.

6 We'll have a roll call.

7 MR. ROATE: Thank you, sir.

8 Senator Demuzio is absent.

9 Dr. Sandra Martell.

10 MEMBER MARTELL: Present.

11 MR. ROATE: Dr. Linda Ray Murray.

12 MEMBER MURRAY: Present.

13 MR. ROATE: Ms. Savage.

14 MEMBER SAVAGE: Present.

15 MR. ROATE: Mr. Slater.

16 MEMBER SLATER: Present.

17 MR. ROATE: Mr. Sewell.

18 CHAIRMAN SEWELL: Present.

19 MR. ROATE: That's five in attendance, sir.

20 CHAIRMAN SEWELL: Thank you.

21 May I have a motion to go into closed
22 session.

23 MEMBER MURRAY: So moved.

24 MEMBER MARTELL: Second.

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1 CHAIRMAN SEWELL: I was going to give the
2 legal support for that --

3 MEMBER MURRAY: Oh, okay.

4 CHAIRMAN SEWELL: -- but you already knew
5 it anyway, pursuant to Section 2(c)(1), 2(c)(5),
6 2(c)(11), and 2(c)(21) of the Open Meetings Act.
7 Already had a motion and a second. All in favor.

8 (Ayes heard.)

9 CHAIRMAN SEWELL: So we need to excuse
10 everyone from this room. And today we have a
11 matter that is a personnel issue, so we're even
12 going to excuse the staff and the ex officio
13 nonvoting members but not legal counsel and not
14 the court reporter.

15 Today this is probably going take, my
16 estimate is, 45 minutes. I'd also like Ms. Olson
17 to stay, our immediate past chair of the board,
18 and Ms. Avery to stay.

19 (At 9:08 a.m. the Board adjourned into
20 executive session. Open session proceedings
21 resumed at 10:12 a.m. as follows:)

22 CHAIRMAN SEWELL: Okay. Let's come to
23 order. I apologize for how long it took us in
24 executive session.

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1 With respect to the agenda, please note
2 that Genesis Health System, No. E-043-19
3 Pipeline-West Suburban Medical Center, E-044-19
4 Pipeline-Louis A. Weiss Memorial Hospital, and
5 Project No. 19-022, Austin Dialysis at Loretto
6 have been moved to the December 2019 agenda. And
7 under "Other Business, Bed Change" has been
8 removed.

9 With those changes, may I have a motion to
10 approve the October 22nd, 2019, agenda?

11 MEMBER SAVAGE: So moved.

12 CHAIRMAN SEWELL: Is there a second?

13 MEMBER MURRAY: Second.

14 CHAIRMAN SEWELL: All in favor.

15 (Ayes heard.)

16 CHAIRMAN SEWELL: Okay. May I have a
17 motion to approve the September 17th, 2019,
18 meeting transcript?

19 MEMBER MURRAY: So moved.

20 CHAIRMAN SEWELL: Is there a second?

21 MEMBER MARTELL: Second.

22 CHAIRMAN SEWELL: All in favor.

23 (Ayes heard.)

24 CHAIRMAN SEWELL: I think we're ready for

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1 public participation, Ann.

2 MS. GUILD: I'm going to call up all the
3 exemptions first. Wade Scott, Dr. Laurie Gordon,
4 Gwendolyn Stanley, Thomas Chorba, Frank Corrado,
5 and Michael McGinty. Hopefully there's enough
6 seats for everyone.

7 You can speak in any order that you would
8 like. Please say and spell your name for the
9 court reporter, and when you're done speaking, if
10 you have written comments that you'd like, please
11 leave them on the table for us.

12 MR. WADE-SCOTT: Good morning, J. Eli
13 Wade-Scott, J, dot, E-l-i W-a-d-e, hyphen, S-c-o-t-t.

14 Members of the Board, good morning. I
15 represent People's Choice Hospital in opposition
16 to the MetroSouth discontinuance application.

17 I understand that the Board, after deferring
18 decision last month, must make a decision today on
19 Quorum's application to discontinue MetroSouth.
20 That decision should be to deny the application.
21 That is for one simple reason, which is that
22 Quorum has disqualified its application by
23 absolutely ignoring this Board's authority over
24 the last month.

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1 When this Board decided to defer decision
2 on Quorum's application, that is, deny them at
3 least for the time the authority to close, Quorum
4 closed the hospital anyway. Within days of this
5 Board refusing to grant them that authority,
6 Quorum closed its ER. Days later they discharged
7 the last inpatient and shuttered the hospital.

8 I urge you to review Mr. Shah's October 2nd
9 letter on the subject as well as Quorum's own
10 statements to you about what they've done.

11 This is not how it works. The purported
12 source of this unilateral authority to close is
13 temporary facility suspension. But that provision
14 is very clear; it's for unforeseen temporary
15 disruptions where there's a plan to reverse and
16 reopen.

17 Quorum has no plan. They have engineered a
18 situation where they had no staff and supposedly had
19 to close, but if that were reason to temporarily
20 suspend a facility, every time an entity applies to
21 discontinue a facility they can stop -- immediately
22 before this Board approves them, they can close
23 the facility, and that is not how it works.

24 Again, it's important that this Board show

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1 that it has authority in this case because going
2 forward this Board should be particularly concerned
3 under new law, it has discretion now to stop
4 entities from doing things and has discretion to
5 deny permits.

6 MR. ROATE: Two minutes.

7 MR. WADE-SCOTT: However, if the Board
8 chooses not to deny the application as you have
9 authority to do so under Statute 20 ILCS 3960.14.1,
10 there are no consequences --

11 MR. ROATE: Two minutes.

12 MR. WADE-SCOTT: -- for entities following
13 this Board's authority. Thank you.

14 DR. GORDON: My name is Dr. Laurie Gordon,
15 L-a-u-r-i-e G-o-r-d-o-n. I've been a practicing
16 dentist in Blue Island for 31 years. I spoke at
17 the last meeting, about 150 years' combined family
18 provision of health care at Blue Island, so
19 keeping this hospital open is very important to me.

20 As one of the small business owners of
21 Blue Island, I fear for the economics of the future
22 of this village or town when 800 jobs are lost and
23 all the businesses that depend on these people
24 will be crushed and livelihoods are destroyed, but

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1 really this is about access to care.

2 By forcing this exemption through, the
3 corporation is limiting the patients' access to
4 care and removing the ability to receive the
5 urgent care that they need. The day after the
6 hospital was closed, a colleague of mine was
7 trying to find emergency care for a 39-week-
8 pregnant patient whose baby was in distress and
9 could not find a place for them to go. I was
10 literally locked out of my own office and had to
11 send away patients who were in pain.

12 I'm urging this Board to do the right
13 thing and ask that they not grant this exemption
14 and do proper due diligence before allowing this
15 company to permanently close MetroSouth Hospital.
16 This shouldn't be about a major corporation's
17 ability to achieve a better bottom line. Lives
18 and livelihoods are at stake, especially because
19 there are candidates willing to buy this health
20 care facility and take over the traditional
21 providing health care in this facility. Even
22 though there are other hospitals that are
23 available sometimes to treat patients, the
24 difference between getting to another hospital

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1 that's on bypass could be the difference between
2 life and death.

3 At the last meeting when emergency room
4 doctors and ambulances are telling -- ambulance
5 drivers are telling us about the situation, this
6 is not something to ignore. If this were our
7 family members, we would want them to have the
8 access to care in a timely fashion.

9 So I urge this Board to do the proper
10 thing, do the proper research necessary, and not
11 let Quorum run over an entire population and
12 community. Thank you.

13 MS. STANLEY: My name is Gwen Stanley,
14 G-w-e-n S-t-a-n-l-e-y. I am a former EVS employee
15 and SEIU member at MetroSouth Hospital Blue
16 Island. I have worked there for 14 years and also
17 live in the neighborhood. Myself and my family
18 are patients at MetroSouth Hospital.

19 I am here because I'm disappointed -- no,
20 I'm not disappointed, I'm angry. This board made
21 a decision that ignores -- made a decision that
22 MetroSouth ignores.

23 On September 20th an overhead page went
24 around the hospital stating that the ER was

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1 shutting down and that the hospital will no longer
2 accept patients. My coworkers and I were shocked.
3 However, we knew it would happen. We had seen
4 that Quorum and MetroSouth knew they were choosing
5 profits over patients.

6 Who I'm disappointed in today is my
7 elected officials. We called on our attorney
8 general to file suit against MetroSouth. Nothing
9 happened. We called on this Board to take action.
10 Still nothing happened.

11 We are here today. The hospital is closed
12 and there are -- have been no consequences for
13 Quorum or MetroSouth. Instead our community
14 continues to suffer and the south land loses
15 another hospital. We are here today to say do
16 your job, protect and enforce the law.

17 Thank you.

18 MR. CORRADO: My name is Frank Corrado.
19 I'm from Evanston.

20 You have today before you what appears to
21 be maybe a routine request from AMITA Healthcare
22 to close its obstetrics unit at Evanston
23 St. Francis Hospital.

24 To everyone involved it looks like a done

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1 deal. The staff has already mostly left; the unit,
2 for all intents and purposes, is already gone, even
3 though AMITA says it will be open until at least
4 December. The only thing needed at this point is
5 a rubber stamp by you folks here today.

6 The arguments are straightforward, only
7 500 births last year. Patients can travel 10 miles
8 to the city to St. Joe's off Lake Shore Drive or
9 almost the same amount of distance to Resurrection
10 on the northwest side, or they could travel up
11 Ridge Avenue to Evanston Hospital which has
12 performed 4,000 births this year. But Navy moms
13 about to give birth may not be able to get to
14 Evanston Hospital since, according to what we
15 know, doesn't take Medicaid. So there's a whole
16 bunch of people not going to be able to use that
17 facility. So what will happen to them now when
18 there's an emergency?

19 This is a large geographic area on the
20 north side of Chicago going to be left without
21 help. We may already have an answer. It's
22 rumored that the first attempt to move a mother in
23 labor from St. Francis to Evanston Hospital had a
24 very unfortunate outcome. Will there be more?

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1 If you give approval to AMITA's request
2 without further close scrutiny, you will be
3 helping create an obstetrics health care desert
4 for thousands of middle and lower income women on
5 the far north side of Chicago. And if the article
6 in today's Tribune -- I'm sure you've seen about
7 Holy Cross Hospital going through the same kind of
8 situation now -- you might wonder if there's --
9 people out here might wonder if there's some sort
10 of a willy-nilly process here for health care
11 decision making. It doesn't look like there's a
12 plan; it looks like there's just actions going on
13 left and right.

14 MR. ROATE: Two minutes.

15 MR. CORRADO: You don't see the big
16 vision. Residents in the neighborhood surrounding
17 St. Francis and thousands of people in nearby --

18 CHAIRMAN SEWELL: Please conclude your
19 remarks.

20 MR. CORRADO: It's a 100-year-old facility
21 which planned their health care --

22 MR. ROATE: Two minutes.

23 CHAIRMAN SEWELL: Sir, please conclude
24 your remarks.

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1 MR. CORRADO: I will. I'm sorry.

2 So Board members, we ask you to help and
3 look forward to helping and delay AMITA's request
4 and demand that they provide concrete answers that
5 you need to ask about leaving a large a number of
6 Chicago's moms underserved. We're not here to
7 help large health care corporations make money by
8 cutting services. Your answer to the communities --
9 you answer to the communities they serve.

10 Do the right thing. Thank you.

11 MR. CHORBA: My name is Tom Chorba,
12 C-h-o-r-b-a.

13 Good morning, distinguished members of the
14 Illinois Health Facilities and Services Review
15 Board. Thank you for allowing me to speak. With
16 my wife Susan and family, I've lived in south
17 Evanston for 45 years. I've been associated with
18 St. Francis Hospital as a medical student,
19 resident, and attending since 1971. I'm a member
20 of St. Nicholas parish Holy Name Society.

21 I cannot say I fully understand the
22 factors that culminated in the decision to close
23 the obstetrical unit at St. Francis.

24 St. Francis Evanston is located in zip

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1 code 60202, also my zip code. 60202 is one of the
2 most densely populated zip codes in America with
3 over 32,000 residents living in its 3 square miles,
4 a density over 10,000 per square mile. St. Francis
5 in 60202 is situated just north and east of zip
6 codes 60659, 60626, and 60076, zip codes with
7 similarly dense populations.

8 It is and has been for 120 years the primary
9 source of health care and portal of entry into the
10 health care system for the roughly 100,000 people
11 living within a 2-mile radius of its location. It
12 is a vital community asset. There is a community
13 expectation that this largely unheralded hospital,
14 St. Francis, will be there for them when they
15 need it.

16 The obstetrical unit has been delivering
17 between 400 to 500 babies -- a not insignificant
18 number of births -- for the past few years in
19 addition to its role as a premier training facility
20 for many of the fine obstetricians now practicing
21 in Evanston, Chicago, and the North Shore.

22 The zip codes associated with these births
23 are overwhelmingly associated with the above-
24 mentioned zip codes and within 2 miles of

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1 St. Francis' location at roughly Oakton and Ridge.
2 For various reasons both economic and social, many
3 of the births are to mothers that are new immigrants,
4 not insured, or on public aid, undoubtedly a
5 strain on hospital finances. As mentioned by the
6 obstetricians at the open hearing held in
7 Evanston, many of the pregnant women do not have
8 cars, must use public transportation, and be seen
9 walking to their appointments with children in hand.

10 Closing the unit and scattering these
11 mothers to find obstetrical care as best they can
12 in the remaining hospitals that are providing
13 obstetrics within 10 miles of St. Francis will
14 cause great hardship.

15 MR. ROATE: Two minutes.

16 MR. CORRADO: The locations make it hard
17 to get to by public transportation, and they will
18 face frosty receptions in the institutions due to
19 the same financial barriers St. Francis has
20 encountered.

21 CHAIRMAN SEWELL: Sir, please conclude
22 your remarks.

23 MR. CORRADO: We ask you keep this unit
24 open. Thank you very much.

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1 MS. AVERY: Sir, can we have your written
2 remarks?

3 MR. CORRADO: Yes.

4 MR. MCGINTY: Good morning and thank you.
5 My name is Michael McGinty. That last name is
6 spelled M-c-G-i-n-t-y. I spoke at the public
7 hearing on October 1st with some others, these
8 two and also doctors and nurses from St. Francis
9 Hospital. So a lot of what I'd say has already
10 been said, so I won't go into that. And I do hope,
11 though, that the Board would look at the series of
12 questions that we did ask AMITA to respond to at
13 that hearing. We worked very hard composing those
14 questions, and I hope that the Board will consider
15 them before making a decision.

16 My issue this morning is perhaps more of a
17 procedural one, procedural in the sense that I
18 hope it's within the spirit of the regulations
19 that you enforce as a Board. But here's what it is.

20 On the exemption AMITA said that this unit
21 would close on October 31st. I heard just a few
22 weeks after that from the nurses at St. Francis
23 that the unit was going to close early and those
24 dates changed. And, finally, it came down to the

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1 end of September, and then early October, and then
2 that unit, as you may know, did close just a couple
3 of weeks ago. They have no nurses, no doctors, no
4 patients.

5 My question is this. If the application
6 said that it was going to close on the 31st of
7 October, why were they allowed to close early, and
8 did they, in fact, supply an amendment to that
9 exemption asking for the early closure?

10 I understand or was told that, on the date
11 of the public hearing, they did provide some sort
12 of a supplementary request to close that unit
13 early. I just hope the Board would consider that
14 as an impact on their application and what it
15 meant to the closing date and all the changes that
16 have taken place subsequent to their original
17 application exemption date of October 31st.

18 MR. ROATE: Two minutes.

19 MR. MCGINTY: Thank you very much.

20 MS. GUILD: Thank you.

21 Next group, starting with Midway Dialysis,
22 Project 19-027, Romie Middleton-Jackson, Irma
23 Lizcano, and Ella Tate.

24 Then on Project 19-037 Provident Hospital,

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1 Dr. Richard Keen and Dr. Arnold Turner.

2 MS. LIZCANO: Good morning. My name is
3 Irma Lizcano. Please approve Midway Dialysis in
4 Chicago's southwest side.

5 I'm here on behalf of myself and others
6 like me who have the disease. Every day there are
7 more people in this neighborhood who find out too
8 late that they have kidney failure when they're
9 hospitalized to get critical care. Every day
10 kidney patients must be very careful for their
11 lifestyle and their diet.

12 Many people, including immigrants like me,
13 don't have the financial resources and support to
14 be successful with their health. Mexicans, who
15 are part of the backbone of our economy in
16 Illinois, have had a hard time adjusting to an
17 American diet and have moved away from a more
18 traditional and healthy diet. Diabetes,
19 hypertension, and obesity are big problems. I am
20 the only skinny person in my family.

21 Life is really hard when you're sick and
22 rely on a machine to do what your kidneys once
23 did. You cannot eat many foods; you must always
24 track how much you drink. And there are always

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1 prescriptions to pay for.

2 With this clinic patients can receive care
3 near their homes. If I need dialysis, I hope to
4 do it at home on my own, and I know DaVita will do
5 what they can to make that happen.

6 The State used to expect people to travel
7 an hour round trip to get this care, but with a
8 better understanding that dialysis close to your
9 home may be the difference between patient
10 compliance and costly hospitalizations, this Board
11 now allows for clinics to be located in every
12 neighborhood where kidney disease is more common.

13 Immediate access to care is even more
14 important for families juggling jobs, kids, and
15 their need to support a sick family member. I know
16 this personally as a gig worker, someone who works
17 several part-time jobs. My life is stressful but
18 this clinic will help people like me.

19 Please approve Midway Dialysis. Thank you.

20 CHAIRMAN SEWELL: I wanted to point out
21 that the project she's referring to is H-03,
22 Project 19-027, DaVita Midway Dialysis in Chicago.

23 MS. MIDDLETON-JACKSON: I'm Romie
24 Middleton-Jackson and I support Midway Dialysis on

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1 the south side of Chicago. Please approve this
2 clinic. Chronic disease trends create this
3 predicament especially in poor areas. This Board
4 must ensure dialysis access to all who need it.

5 There are clear health care disparities and
6 socioeconomic disadvantages for so many Chicago
7 residents. These are marginalized communities
8 with associated high kidney disease rates. Poor
9 residents seldom receive early intervention.
10 Instead they "crash" into dialysis and only learn
11 they are sick when it's too late to stop kidney
12 failure.

13 Many people can't afford their diabetes
14 drugs and supplies. They pay high out-of-pocket
15 costs for these insulin, testing, and injection
16 supplies and doctor visits. These costs are hard
17 to manage for people making a living wage, but
18 they are simply not affordable for low-income
19 families whose affected household members must
20 ration their insulin and test less than they
21 should. Illinois has created a prescription drug
22 affordability committee, but reform may not happen
23 since big pharma will always fight lower prices.

24 Dialysis is not a choice. For those who

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1 have lost their kidneys, they get this essential
2 treatment three days a week for three to four hours.
3 Without dialysis they do not survive. Even a
4 single missed treatment can result in a very high-
5 cost hospitalization which hurts families,
6 taxpayers, and employers. Transport issues,
7 illness, or scheduling problems are common. These
8 hospitalizations represent a failure of health
9 planning because they indicate barriers for these
10 patients to get to clinic and reschedule their
11 treatments when needed.

12 Dialysis is hard. Let's hope none of us
13 have to walk a day in the shoes of a person with
14 kidney failure. Please approve Midway Dialysis.

15 MS. TATE: Hi, my name is Minister Ella Tate,
16 and I support Midway Dialysis.

17 With the 80-station need it identified,
18 this Board has issued a directive to providers to
19 build seven more clinics in Chicago. This
20 University of Chicago-backed clinic will serve an
21 unserved community that is hurt by health
22 disparities.

23 Kidney disease runs in my family. My
24 sister passed from kidney failure complications.

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1 A Type 1 diabetic, her trouble started as a child,
2 and she eventually lost her kidneys. She received
3 a transplant but the anti-rejection drug gave her
4 cancer. Beyond that, my mother and my daughter's
5 father have ESRD.

6 My mom gets treatments three times a week,
7 and our family must band together so she is
8 compliant with her treatment. We take turns
9 taking her to appointments. I take off every
10 Wednesday through unpaid family leave. She is
11 poor but because of the tricks the State has
12 played to keep people off Medicaid, we have been
13 unable to secure transport through that program,
14 so we make the sacrifice to keep her with us.

15 As a working single mother with two kids
16 and a grandchild, I have many responsibilities and
17 rise by 4:30 every weekday, and getting Mom to
18 dialysis is top priority. Between going from my
19 house to my mom's back and forth to the clinic,
20 this is about seven hours of my day.

21 My experience with kidney disease is
22 personal to me. The reality is that so many
23 people in the community have similar needs, and
24 these clinics are their lifeline. This clinic

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1 will ensure families like mine can have the
2 service close to home with some options for the
3 treatment time. This helps to ensure patient
4 compliance and avoid costly hospitalizations.

5 For my mom, and in the memory of my sister,
6 and on behalf of my congregation and the rest of
7 my community, please approve Midway Dialysis.
8 Thank you.

9 MS. GUILD: The next two projects are
10 Provident.

11 DR. ARNOLD: Good morning. I am
12 Dr. Arnold, A-r-n-o-l-d, Turner, T-u-r-n-e-r. I
13 am a board certified internist and medical
14 director of Provident Hospital of Cook County.
15 Before joining Cook County health in October 2016,
16 I practiced on the south side of Chicago for more
17 than 30 years in academic settings involving the
18 teaching of medical students and residents.

19 In our primary clinic where I see patients,
20 we provide care through the primary care medical
21 home model that emphasizes prevention, health
22 maintenance, education, and chronic disease
23 management. Care is provided to each patient by a
24 team consisting of physicians, advanced practice

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1 providers, nurses, medical assistants, and social
2 workers. The clinic is currently located on a
3 previous hospital inpatient floor. Seeing
4 patients in hospital rooms impairs our ability to
5 see patients efficiently and practice as a team.

6 Despite these limitations, we have
7 continued to increase our clinic volume yearly
8 through workflow optimization and adding
9 additional providers. The continued growth in
10 both the primary care and specialty clinics
11 indicates the need for these services. We are
12 also expanding specialty services to better meet
13 the needs of our patients.

14 To provide high quality and convenient
15 care to our patients, we must have diagnostic
16 imaging services. Our continued growth is
17 reflected in the increase radiology procedures
18 that will exceed 15,800 this year. With the
19 addition of specialty services that will require
20 X-ray support such as orthopedic surgery, the
21 volume for X-rays will continue to increase and
22 exceed the volume needed for rooms requested. The
23 same is true for ultrasound. We have implemented
24 an action plan to increase the mammography volume,

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1 which includes outreach through direct calls to
2 women to schedule mammograms.

3 Having primary care and specialty care
4 located in one location helps us to provide the
5 right care at the right time. Our medical/
6 surgical hospital unit is staffed for 25 patients.
7 Since we reopened the ICU, sometimes we are at
8 capacity. With the resumption of ambulance runs
9 and surgery cases that will require --

10 MR. ROATE: Two minutes.

11 DR. TURNER: -- an overnight stay, we will
12 satisfy the requirement for the requested beds.

13 Thank you for this opportunity.

14 DR. KEEN: Good morning. My name is
15 Richard Keen, and I'm a practicing vascular
16 surgeon and the chair of surgery for Provident
17 Hospital and Stroger Cook County Hospital.

18 Stroger Cook County hospital, without
19 Provident Hospital, is unable to accommodate the
20 number of patients who require surgery. Stroger
21 Hospital cares for many emergency and trauma
22 cases, with the result that elective, nonemergent
23 surgery often gets canceled the day of surgery due
24 to lack of any additional operating room capacity

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1 at Stroger. This unavoidable result causes
2 tremendous inconvenience to patients and their
3 families.

4 The solution is to redirect elected
5 surgery patients from Stroger to Provident and
6 utilize our existing 10 Provident operating rooms.
7 In the next two years we plan to utilize fully
8 nine existing Provident ORs for operations and
9 procedures.

10 The new Provident Hospital, with eight
11 operating and four procedure rooms, is necessary
12 to accommodate both our existing backlog of
13 surgical patient and the anticipated increases in
14 the number of charity care cases that County will
15 accept going forward.

16 The new Provident Hospital is located
17 strategically as a south side community hospital,
18 continuing its history of serving the needs of the
19 underserved residents from the heart of the city
20 and the southern suburbs which is the largest
21 source of the county's surgical patients.

22 There exists a dearth of specialty care
23 for the underserved in the Chicago metropolitan
24 area. The wait times for elective surgery at

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1 Stroger Hospital can be months. Patients
2 meanwhile endure suffering when a surgical
3 intervention could resolve the medical issue.

4 The expanded surgical services in the new
5 Provident Hospital will play a critical role in
6 delivering expanded specialty surgical care for
7 the needy in vision loss surgery to prevent
8 blindness in patients suffering from diabetes,
9 bladder continence surgery for women embarrassed
10 to go out in public, limb salvage surgery to
11 prevent amputation from vascular disease, breast
12 cancer surgery for minority women with a
13 disproportionately high mortality rate, increased
14 endoscopy and colon and stomach cancer detection
15 services, bariatric surgery to treat the obesity
16 epidemic, and hand and shoulder surgery for men
17 and women who require functional upper extremities
18 to remain gainfully employed.

19 MR. ROATE: Two minutes.

20 DR. KEEN: Thank you for your consideration
21 of this critical proposal.

22 MS. GUILD: The next group is Sauganash
23 Dialysis. Martha Gonzales, Hamid Humayun, George
24 Kocalis, and Ted Simmons.

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1 MR. SIMMONS: Thank you all. My name is
2 Ted Simmons, S-i-m-m-o-n-s. I'm the CEO and
3 facility administrator at Center for Renal
4 Replacement, an independent family-owned business
5 in Lincolnwood, 16 stations. I'm here obviously
6 in opposition of the DaVita project.

7 There's a couple of reasons why. Mainly
8 it revolves around utilization.

9 It seems this process has changed a lot
10 since we first opened up our facility and had to
11 sit before a board like this one. Basically, we
12 had to prove that there was a current need for a
13 16-station facility. It seems today the process
14 of -- we're not notified. We had to notify other
15 facilities by certified mail, registered letters
16 of our intent. That process seems to be gone now.

17 I only bring that up because there's
18 another treater that opened just down the street
19 from us, about 2 miles, several years ago. Again,
20 we had no knowledge of that unit opening up.

21 And it just seems like the process of the
22 acquisitions by DaVita and the building of new
23 facilities by DaVita really hurts the independent
24 center, and I think the independent center is very

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1 important to the dialysis community. It affords
2 things that large corporations can't.

3 So I'm hoping that you will deny the
4 petition by DaVita. Thank you.

5 DR. HUMAYUN: I'm Dr. Hamid Humayun. I'm
6 one of the nephrologists practicing in the area
7 for 35, 40 years as a medical doctor at one of the
8 dialysis units in the area, Nephron. You know, we
9 have a very small independent dialysis facility,
10 and DaVita is opening units in the area, and there
11 are at least four dialysis units in the area which
12 are running at below capacity. Some are running
13 at 53 percent, some are 59 percent, so they are
14 really not at capacity.

15 I think with the present ruling, with the
16 executive order which says that by 2025 80 percent
17 of the dialysis will move from in center to the
18 home, and that is the order of the president. And
19 I go to a lot of dialysis meetings, and I think
20 that every dialysis provider is trying to see how
21 we could move these patients to home from a center
22 and that's happening.

23 So I think we have excess capacity in all
24 the existing dialysis units, and this capacity is

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1 probably going to increase because there will be a
2 lot of patients moving home rather than taking
3 dialysis in the center.

4 So I think I would suggest that we probably
5 do not approve more chairs because there's excess
6 capacity already. Thank you for listening.

7 MR. KOCALIS: Good morning. My name is
8 George Kocalis, K-o-c-a-l-i-s. I'm here in
9 opposition, as well, and I agree with both the
10 gentlemen that spoke before me.

11 I have a few words I'd like to read here.
12 Unfortunately, I didn't get my letter in on time.

13 So thanks for hearing my testimony today.
14 Let me begin with, of the five centers proposed --
15 of the five centers in the proposed area for this
16 unit, four of them are below this 80 percent
17 threshold, as you well know, two of which are
18 close to 50 percent, and this violates the rule
19 requirement for the CON. IDPH has estimated zero
20 to little growth in the city of Chicago now from
21 2017 to 2022.

22 Based on these facts alone, the application
23 should be denied, but I'd like to make the Board
24 aware of something else that's been going on.

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1 Over the years, particularly more recently,
2 DaVita has offered multiple times to purchase our
3 facility and/or do some sort of joint venture. I
4 also know that they engaged with CRR for this very
5 same reason. This proposed project is an obvious
6 underhanded attempt to negatively impact Nephron
7 and CRR for the sole purpose of putting a financial
8 strain on both these centers in an attempt to
9 force a possible sale in the future. This is even
10 more evident in that the proposed location is
11 nearly equal distance between the two independent
12 centers.

13 You could draw a straight line on a map
14 between these three centers if it was to be
15 accepted, which would put each one less than
16 five minutes apart, and this is in the city of
17 Chicago.

18 DaVita seems so fixated on taking over the
19 market share as possible that they're willing to
20 proceed at the detriment of one of their own
21 centers, DaVita Big Oaks. Other than the fact that
22 they wish to negatively affect two other centers,
23 there's Fresenius, which is also below the
24 80 percent threshold.

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1 Beyond the politics of business, there's a
2 very real concern for patient choice. It is
3 important to know that there are only
4 two independent units in the city of Chicago, just
5 two of us. When patients are blackballed from one
6 of the LDOs, they have no options. What's at
7 stake here is patient choice.

8 MR. ROATE: Two minutes.

9 MR. KOCALIS: I strongly urge you to deny
10 this DaVita project. Thank you very much.

11 MS. GONZALES: Me llamo Martha Gonzales.
12 Please approve the Sauganash dialysis clinic.

13 This clinic will help people like me who
14 live in northwest Chicago who need treatment
15 because their kidneys do not work.

16 Por muchas personas -- for many people
17 this treatment is life or death. Mucha gente
18 hispana en Chicago -- Mexicans -- have kidney
19 disease plus diabetes o alta presion -- high blood
20 pressure. These enfermedades -- sicknesses --
21 hurt the kidneys. And our people are poor,
22 pobres.

23 It is so hard to live with health
24 problems, and if you need dialysis, life is never

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1 the same. We all must care for our bodies,
2 nuestra salud, but if the kidneys are already
3 dying, it can be too late to fix.

4 Gracias a dios por ERIE, Centros de Salud
5 Familiar for helping people like me, but we do not
6 all get help. For most in my community there is
7 never enough time in the day for everything you
8 must do and their health suffers.

9 DaVita provides very good care. This
10 clinic will help many people. Please vote yes
11 DaVita in Sauganash. Gracias por tu tiempo hoy.

12 MS. GUILD: Thank you.

13 Was there anyone else in the audience who
14 had public participation comments? And if you
15 have written comments, please leave them with us.

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1 CHAIRMAN SEWELL: And for the exemptions,
2 on the agenda for exemption requests is C-01,
3 Project E-024-19, MetroSouth Medical Center in
4 Blue Island.

5 May I have a motion to approve Exemption
6 E-024-19, MetroSouth Medical Center to discontinue
7 a 314-bed acute care hospital in Blue Island? Is
8 there a motion?

9 MEMBER SLATER: Yes, I make a motion.

10 CHAIRMAN SEWELL: Is there a second?

11 MEMBER MARTELL: Second.

12 CHAIRMAN SEWELL: Would you please
13 introduce yourselves -- hold on. The
14 administrator wants to make a statement.

15 MS. AVERY: Board members, you received
16 the court order from Judge Mullen last Friday in
17 court that stated that the Board shall take up the
18 issue of MetroSouth at its October 22nd meeting,
19 so it specified which meeting. And according to
20 the Planning Act that this application falls under,
21 the State Board shall establish by regulation the
22 procedures and requirements regarding the issuance
23 of exemption.

24 "An exemption shall be approved when

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1 information required by the Board by rule is
2 submitted. Projects eligible for an exemption
3 rather than a permit include but are not limited
4 to change of ownership of a health care facility,
5 discontinuation of a category of service, and
6 discontinuation of a health facility."

7 So under the direction of the Court, you
8 must take action in accordance with the rule on
9 today, October 22nd.

10 CHAIRMAN SEWELL: Now could you introduce
11 yourself.

12 MR. LAWLER: Thank you, Chairman Sewell.
13 My name is Dan Lawler. I'm with the law firm of
14 Barnes & Thornburg in Chicago. Sitting to my
15 right is Mr. John Walsh, the CEO of MetroSouth
16 Medical Center, and to my left is Marty Smith, the
17 COO of Quorum.

18 Mr. Walsh and Mr. Smith presented to you
19 at last month's meeting. They would be prepared
20 to present again if you'd like, but they're also
21 here to answer questions that the Board may have.

22 I would just like to add to Ms. Avery's
23 statement that in court last Friday --

24 CHAIRMAN SEWELL: Excuse me. You need to

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1 be sworn in.

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

4 (Three witnesses sworn.)

5 THE COURT REPORTER: Thank you.

6 CHAIRMAN SEWELL: I'm sorry. Continue.

7 MR. LAWLER: Yes. The Honorable Michael
8 Mullen of the Circuit Court of Cook County found
9 that -- stated, "It is clear, based upon the
10 statutory requirements, that the plaintiff has
11 complied with the statutory requirements in all
12 respects, and it is entitled to a decision."

13 And he went on to say that, "I am granting
14 the writ as requested in the sense of requiring a
15 decision based upon the application which has been
16 deemed to be fully complete as of June 12th."

17 And then I would note on the front page of
18 your staff reports the staff has quoted the
19 provision of the Planning Act that states, "An
20 exemption shall be approved when information
21 required by the Board by rule is submitted," and
22 the Court found that we have submitted that
23 information.

24 Thank you.

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1 CHAIRMAN SEWELL: Any questions by members
2 of the Board or comments?

3 MEMBER MURRAY: I'd just like to be reminded
4 by the staff about the findings in last month's.
5 Were there any failures in the report from last
6 month? I don't remember any but I'm asking.

7 MR. CONSTANTINO: No, they provided all
8 the information required by the Board.

9 CHAIRMAN SEWELL: Ms. Avery, you look like
10 you want to say something.

11 MS. AVERY: No, I'm fine.

12 CHAIRMAN SEWELL: Anyone else?

13 MEMBER SAVAGE: I guess I would want to
14 ask, I'm not certain who, since the hospital
15 closed before the final decision, is there
16 anything that we should consider because of that?

17 MS. AVERY: I have reached out to Karen
18 Singer, IDPH, and I'm waiting on the formal report
19 from her. If you would notice on the agenda, which
20 we will go back to, there was a referral to legal,
21 and I'm going to ask the Board once I receive that
22 report and evaluate it if we need to make a
23 referral to legal for noncompliance of the
24 hospital shutting down prior to receiving the

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1 certificate of exemption.

2 There was a temporary suspension of
3 services that was submitted. Can you provide me
4 with that date?

5 MR. CONSTANTINO: We received it on the 27th.

6 MS. AVERY: So all of that will be taken
7 into consideration, so I should have something for
8 you formally in December.

9 CHAIRMAN SEWELL: Okay. If there are no
10 other questions or comments, roll call.

11 MR. ROATE: Thank you, sir.

12 Motion made by Mr. Slater; seconded by
13 Dr. Martell.

14 Dr. Martell.

15 MEMBER MARTELL: I vote in support based
16 on the staff report.

17 MR. ROATE: Thank you.

18 Dr. Murray.

19 MEMBER MURRAY: Yes, based on staff report.

20 MR. ROATE: Thank you.

21 Ms. Savage.

22 MEMBER SAVAGE: Yes, based on staff report.

23 MR. ROATE: Thank you.

24 Mr. Slater.

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1 MEMBER SLATER: Yes, because they're in
2 conformance with all the requirements.

3 MR. ROATE: Thank you.
4 Chairman.

5 CHAIRMAN SEWELL: I vote yes but I'd like
6 to say for those who were advocating a no on this
7 that when it comes to exemption requests and
8 discontinuations, the Board's ability to come up
9 with findings is very limited.

10 So here is a project where the State
11 agency report has no findings, and there would
12 then be no basis for Board members to vote no on
13 this project.

14 So, again, I vote yes.

15 MR. ROATE: Thank you.

16 That's 5 votes in the affirmative.

17 MR. LAWLER: Thank you.

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1 CHAIRMAN SEWELL: Okay. Next on the
2 agenda is C-02, Project No. E-038-19, Elmhurst
3 Memorial Hospital in Elmhurst.

4 May I have a motion to approve this
5 exemption request to discontinue its six-bed
6 pediatric category of service.

7 MEMBER SAVAGE: So moved.

8 CHAIRMAN SEWELL: Is there a second?

9 MEMBER MURRAY: Second.

10 CHAIRMAN SEWELL: Could you introduce
11 yourself and be sworn in.

12 MS. NGUYEN: My name is Minh, M-i-n-h;
13 Nguyen, N-g-u-y-e-n. I'm the director of service
14 and planning at Edward-Elmhurst Health.

15 MS. SABA: Good morning. My name is
16 Yvette, Y-v-e-t-t-e, Saba, S-a-b-a, assistant vice
17 president, operations at Edward-Elmhurst Health.

18 MR. SULLIVAN: Good morning. My name is
19 Daniel Sullivan, D-a-n-i-e-l S-u-l-l-i-v-a-n, and
20 I'm the chief medical officer at Elmhurst Memorial
21 Hospital.

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

24 (Three witnesses sworn.)

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1 THE COURT REPORTER: Thank you.

2 CHAIRMAN SEWELL: State agency report.

3 MR. CONSTANTINO: Thank you, Mr. Chairman.

4 Elmhurst Memorial Hospital is asking the
5 board to approve the discontinuation of a six-bed
6 pediatric category of service at its acute care
7 hospital in Elmhurst, Illinois.

8 The reason for the discontinuation is the
9 low utilization for pediatric category of service.
10 No public hearing was requested. No letters of
11 support or opposition were received. There was no
12 cost to the discontinuation, and the expected
13 completion date is November 30th, 2019.

14 The applicants have addressed all the
15 requirements of the State board.

16 Thank you, sir.

17 CHAIRMAN SEWELL: Do you have a
18 presentation for the Board?

19 MS. SABA: Have had no statements and are
20 just here to answer any questions you have.

21 CHAIRMAN SEWELL: Board members have any
22 questions or comments?

23 Yes, Dr. Martell.

24 MEMBER MARTELL: I wanted to ask a

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1 question regarding the plan for the pediatric
2 emergency department.

3 MS. NGUYEN: Can you repeat the question?

4 MEMBER MARTELL: The plan for a pediatric
5 emergency department.

6 MR. SULLIVAN: So for our emergency
7 department we will still take care of all the
8 pediatric people that come in. We're trained for
9 pediatrics, but we're not specialty trained.

10 If somebody needs to be admitted, we will
11 either bring them over to our Edward facility, if
12 that's what their agreement is, or we will
13 transfer them to another facility of their liking.

14 CHAIRMAN SEWELL: Okay. Could we have a
15 roll call?

16 MR. ROATE: Thank you, sir.

17 Motion made by Ms. Savage; seconded by
18 Dr. Murray.

19 Dr. Martell.

20 MEMBER MARTELL: I vote in support based
21 on staff report and performance.

22 MR. ROATE: Dr. Murray.

23 MEMBER MURRAY: Yes, based on staff report.

24 MR. ROATE: Thank you.

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1 Ms. Savage.

2 MEMBER SAVAGE: Yes, based on staff report.

3 MR. ROATE: Thank you.

4 Mr. Slater.

5 MEMBER SLATER: Yes, based on staff report.

6 MR. ROATE: Thank you.

7 Chairman Sewell.

8 CHAIRMAN SEWELL: Yes, based on the State
9 agency report.

10 MR. ROATE: Thank you.

11 That's 5 votes in the affirmative.

12 CHAIRMAN SEWELL: Thank you.

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1 CHAIRMAN SEWELL: Okay. Next on the
2 agenda is C-03, Project No. E-040-19, AMITA Health
3 St. Francis Hospital Evanston.

4 May I have a motion to approve an
5 application to discontinue an 18-bed obstetric
6 category of service.

7 MEMBER SAVAGE: I so move.

8 CHAIRMAN SEWELL: Is there a second?

9 MEMBER MURRAY: Second.

10 MS. AVERY: Members, in light of what
11 you've heard today, I'll go through the same
12 process as I described with MetroSouth Medical
13 Center.

14 We did receive on the day of public hearing
15 a notice to temporarily suspend the services for
16 this, and I am reaching out to the Department of
17 Public Health for a report in order to figure out
18 exactly when the services were discontinued at
19 this facility.

20 So once I receive that information, I will
21 come back to you in December, present it to you,
22 and ask for referral to legal.

23 Thank you.

24 CHAIRMAN SEWELL: All right. Could you

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1 identify yourselves and be sworn in.

2 MR. JONES: Kenneth Jones, K-e-n-n-e-t-h
3 J-o-n-e-s, president, St. Francis Hospital.

4 DR. SIGLIN: Dr. Martin Siglin,
5 M-a-r-t-i-n S-i-g-l-i-n, chief medical officer of
6 St. Francis Hospital Evanston.

7 MR. AXEL: Jack Axel, Axel & Associates,
8 A-x-e-l.

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

11 (Three witnesses sworn.)

12 THE COURT REPORTER: Thank you.

13 CHAIRMAN SEWELL: State agency report.

14 MR. CONSTANTINO: Thank you, Mr. Chairman.
15 St. Francis Hospital in Evanston is asking
16 the Board to approve the discontinuation of an
17 18-bed obstetric category of service at its acute
18 care hospital in Evanston. The reason for the
19 discontinuation is the low utilization for
20 obstetric care.

21 A public hearing was held on October 1st,
22 2019, and there were both support and opposition
23 comments provided at that hearing.

24 There is no cost to the discontinuation, and

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1 the expected completion date is November 30th, 2019.

2 The applicants have provided all the
3 information required by the State Board.

4 Thank you, sir.

5 CHAIRMAN SEWELL: Yes. Do you have a
6 presentation?

7 MR. JONES: Good morning. My name is
8 Kenneth Jones, and I'm president of AMITA Health
9 St. Francis Evanston.

10 The decision to close our OB program at
11 St. Francis was not an easy one, but after months
12 of analysis we realized that the time had come.
13 Deliveries were down from 730 in 2014 to 502 in 2018.

14 Once we made the decision that we need to
15 discontinue service, we turned our attention to
16 making sure that we were taking all reasonable steps
17 to ease our community's transition. We met with
18 Evanston Hospital, our closest hospital, and were
19 able to develop a formal obstetrics transfer
20 agreement with them. Over 3500 babies are
21 delivered annually at Evanston Hospital, and the
22 hospital operates a Level III neonatology
23 intensive care unit.

24 We also put obstetrics transfer agreements

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1 in place with two of our sister hospitals, AMITA
2 Health St. Joseph Hospital and AMITA Health
3 Resurrection Medical center, both also located
4 within the Board's designated service area. We
5 evaluated the OB/GYN programs we offer other than
6 deliveries and will continue to provide prenatal
7 care, routine screenings, prenatal education
8 classes, and breast imaging.

9 We developed a program to provide
10 transportation for OB patients in need of
11 assistance through an arrangement we put in place
12 with Lyft. We met with our partners at designated
13 areas to discuss the impact on patient care. We
14 created expedited medical staff membership
15 application processes for any of our obstetricians
16 desiring to admit patients at AMITA St. Joseph
17 Hospital or AMITA Resurrection Medical Center. We
18 have made sure that our emergency department is
19 fully staffed with expertise to handle 24/7
20 emergencies and to equip themselves with the rare
21 OB walk-ins.

22 With those comments we are happy to answer
23 your questions.

24 CHAIRMAN SEWELL: Are there questions from

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1 Board members?

2 (No response.)

3 CHAIRMAN SEWELL: Can we have a roll call
4 on the motion?

5 MR. ROATE: Motion made by Dr. Martell;
6 seconded by Dr. Murray.

7 Dr. Martell.

8 MEMBER MARTELL: Yes, based on
9 performance, staff report, and testimony.

10 MR. ROATE: Dr. Murray.

11 MEMBER MURRAY: Yes, based on staff report.

12 MR. ROATE: Thank you.

13 Ms. Savage.

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

16 MR. ROATE: Thank you.

17 Mr. Slater.

18 MEMBER SLATER: Yes, based on staff
19 report.

20 MR. ROATE: Thank you.

21 Chairman Sewell.

22 CHAIRMAN SEWELL: Yes. Based on the staff
23 report.

24 MR. ROATE: Thank you. That's 5 votes in

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1 the affirmative.

2 CHAIRMAN SEWELL: Thank you.

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1 CHAIRMAN SEWELL: Next on the agenda is
2 C-04, Project No. E-042-19, DaVita Marion Dialysis
3 in Marion.

4 May I have a motion to approve this
5 project to discontinue a 13-station end-stage
6 renal disease facility.

7 MEMBER SAVAGE: So moved.

8 CHAIRMAN SEWELL: Is there a second?

9 MEMBER MARTELL: Second.

10 CHAIRMAN SEWELL: Could you introduce
11 yourselves.

12 MS. COOPER: Anne Cooper, counsel for
13 DaVita.

14 MS. COX: Regina Cox, regional operations
15 director for DaVita.

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

18 (Two witnesses sworn.)

19 THE COURT REPORTER: Thank you.

20 CHAIRMAN SEWELL: State agency report.

21 MR. CONSTANTINO: Thank you, Mr. Chairman.

22 DaVita, Incorporated, proposes to discontinue
23 a 13-station ESRD facility in Marion, Illinois.
24 There is no cost to this project, and the

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1 anticipated completion date is October 23rd, 2019.

2 As I put on the second page of the staff
3 report, I had inadvertently accepted this
4 application as an exemption. At that time the Act
5 had been changed, and this was submitted after the
6 Act had been changed. Therefore, we went ahead
7 and accepted the application and reviewed it as a
8 certificate of need application, which essentially
9 states to the Board they can turn this down. No
10 matter what our Board staff says, they can accept
11 the report as is or defer the project or give it
12 an intent to deny.

13 Thank you, Mr. Chairman.

14 CHAIRMAN SEWELL: Okay. I have a question
15 about that. We can vote yes or no regardless of
16 the classification of the application?

17 MR. CONSTANTINO: Not for an exemption.

18 CHAIRMAN SEWELL: But it's not an exemption;
19 correct?

20 MR. CONSTANTINO: No, it's a certificate
21 of need.

22 CHAIRMAN SEWELL: I see. So that's the
23 reason. It's not regardless of what the State
24 agency report says?

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1 MR. CONSTANTINO: Yes.

2 CHAIRMAN SEWELL: Okay. I just wanted to
3 be clear on that.

4 MR. CONSTANTINO: Yeah. We had no findings
5 on the State Board staff report.

6 CHAIRMAN SEWELL: Okay. Do you have a
7 presentation?

8 MS. COOPER: No. We'd like to thank the
9 staff for their help in this application, and we're
10 here to answer any questions that you may have.

11 CHAIRMAN SEWELL: Do Board members have
12 questions or comments?

13 MEMBER SLATER: I notice that Fairfield
14 and Redbud are within your jurisdiction. Right?

15 MS. COOPER: They're within the HSA but
16 not within the actual geographic service area.

17 MEMBER SLATER: But they're at about the
18 same usage level at Marion is. So is there a plan
19 to close those down, as well?

20 MS. COX: I'm actually not the regional
21 operations director for that facility but not to
22 my knowledge.

23 MEMBER SLATER: Southern Illinois is a
24 huge area, and when you take those small towns and

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1 look at them, it's a little bit different
2 situation from looking at it in a metro area.

3 So there's -- in this particular case
4 there happens to be two units or two facilities in
5 the same town.

6 MS. COX: That's correct.

7 MEMBER SLATER: So that's kind of covered.

8 MS. COX: Right.

9 MEMBER SLATER: But I'm concerned -- I
10 mean, there's still DaVita operations in Redbud
11 and Fairfield, and the usage is about the same as
12 in Marion. So are we going to see next time
13 around an application to close those?

14 MS. COOPER: At this point that's not my
15 understanding they plan to close any. This is the
16 only facility they're planning on closing.

17 As you mentioned, the reason behind it is
18 because of the low utilization at this clinic, and
19 these patients will transfer to the other Marion
20 clinic and to other DaVita clinics in the area,
21 and that will actually help those clinics achieve
22 or get closer to the State Board standard and also
23 will return 13 stations to the inventory. Currently
24 there's an excess of 20 stations in this health

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1 services area.

2 CHAIRMAN SEWELL: Other questions?

3 (No response.)

4 CHAIRMAN SEWELL: Can I have roll call.

5 MR. ROATE: Thank you, sir.

6 Motion made by Ms. Savage; seconded by
7 Dr. Martell.

8 Dr. Martell.

9 MEMBER MARTELL: I vote yes based on staff
10 report and testimony.

11 MR. ROATE: Thank you.

12 Dr. Murray.

13 MEMBER MURRAY: I vote yes based on staff
14 report.

15 MR. ROATE: Thank you.

16 Ms. Savage.

17 MEMBER SAVAGE: I vote yes based on staff
18 report.

19 MR. ROATE: Thank you.

20 Mr. Slater.

21 MEMBER SLATER: I vote yes based on the
22 fact that there are two facilities in Marion,
23 Illinois.

24 MR. ROATE: Thank you.

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1 Chairman Sewell.

2 CHAIRMAN SEWELL: I vote yes based on the
3 staff report.

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

6 CHAIRMAN SEWELL: Thank you.

7 MS. COOPER: Thank you.

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1 CHAIRMAN SEWELL: Next project is C-07,
2 No. E-045-19, AMITA Alexian Brothers Medical
3 Center in Elk Grove Village.

4 May I have a motion to approve this
5 project to discontinue a 25-bed AMI category of
6 service?

7 MEMBER SAVAGE: So moved.

8 CHAIRMAN SEWELL: Is there a second?

9 MEMBER MURRAY: Second.

10 CHAIRMAN SEWELL: All right. Could you
11 introduce yourselves and then be sworn in.

12 MR. CIHA: Good morning. Clayton Ciha,
13 last name C-i-h-a. I'm the CEO of Alexian
14 Brothers Behavioral Health and AMITA Behavioral
15 Medicine Service Line.

16 DR. D'AGOSTINO: I'm Christopher D'Agostino.
17 I am the chief medical officer at Alexian Brothers
18 Behavioral Health Hospital and the geriatric
19 service line director, as well, at that facility.

20 MR. AXEL: Jack Axel, Axel & Associates.

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

23 (Two witnesses sworn.)

24 THE COURT REPORTER: Thank you.

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1 CHAIRMAN SEWELL: State agency report.

2 MR. CONSTANTINO: Thank you, Mr. Chairman.

3 Alexian Brothers Medical Center is asking
4 the Board to approve the discontinuation of a
5 25-bed acute mental illness category of service at
6 their acute care hospital in Elk Grove Village,
7 Illinois.

8 The reason for the discontinuation is the
9 hospital has had difficulty in attracting
10 psychiatrists to its medical staff, and as a
11 member of AMITA health, there are two other mental
12 illness problems in the area, AMITA Alexian
13 Brothers Behavioral Hospital Hoffman Estates and
14 Chicago Behavioral Health in Des Plaines.

15 No public hearing was requested, and no
16 letters of support or opposition were received by
17 the Board.

18 There is no cost to the discontinuation, and
19 the expected completion date is November 30th, 2019.
20 The applicants have provided all the information
21 required by the State Board.

22 Thank you, sir.

23 CHAIRMAN SEWELL: Do you have a
24 presentation?

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1 MR. CIHA: Thank you. I'm here today to
2 talk about the consolidation of the psychiatric
3 program. AMITA Health is one of the largest
4 providers of psychiatric services in the northwest
5 suburbs. We have over 300 beds there. We have
6 another 300 to 320 people in ambulatory services,
7 and if you look across our entire behavioral
8 health network, we have over 600 psychiatric beds.
9 We are not shying away from behavioral health
10 services. We embrace it and are looking forward
11 to that.

12 In 2014 we opened the Alexian Brothers
13 Medical Center program. The 25-bed unit peaked at
14 about 14 to 15 patients and has continued to
15 diminish over the past year or so. By moving the
16 patient population, it would allow us to have a
17 single stronger program with more beds at a nearby
18 site without having to spread our resources thinly
19 between two programs.

20 Alexian Brothers Behavioral Health Hospital
21 is 15, 20 minutes away. It's fully staffed with
22 existing older adult services, and that's the
23 program that we have there is a geriatric
24 psychiatric program, so we have units and capacity

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1 to handle the additional cases.

2 We don't envision any significant impact
3 on accessibility. For example, we just won the
4 Illinois Hospital Association innovation award for
5 our logistics program, which reduces the amount of
6 time people have to wait for beds and can locate a
7 bed in our system very swiftly and move people
8 smoothly there. By consolidating the programs
9 there's better flexibility for our associates and
10 reduces the likelihood of them being called off
11 shifts.

12 All of our associates, all of our
13 physicians that are currently in this program will
14 be offered jobs and have been offered jobs and
15 have accepted positions at the behavioral health
16 hospital, so it will not affect the employment of
17 anyone there.

18 We will continue to provide all the
19 assessments at Alexian Brothers Medical Center
20 both on the acute care units for behavioral
21 health, as well as the emergency department as we
22 always have.

23 The project has received no opposition
24 from the provider community, the public, community

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1 in general, or any of our elected officials.

2 We're pleased to answer any questions.

3 CHAIRMAN SEWELL: Are there questions?

4 (No response.)

5 CHAIRMAN SEWELL: Can we have a roll call,
6 George?

7 MR. ROATE: Thank you, sir.

8 Motion made by Ms. Savage, seconded by
9 Dr. Murray.

10 Dr. Martell.

11 MEMBER MARTELL: I vote in support based
12 on staff report and testimony.

13 MR. ROATE: Thank you.

14 Dr. Murray.

15 MEMBER MURRAY: I support it based on
16 staff report.

17 MR. ROATE: Thank you.

18 Ms. Savage.

19 MEMBER SAVAGE: I vote yes based on staff
20 report and testimony.

21 MR. ROATE: Thank you.

22 Mr. Slater.

23 MEMBER SLATER: Yes, based on the staff
24 report, and the same services will be provided by

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1 the Hoffman Estates facility.

2 MR. ROATE: Thank you.

3 Chairman Sewell.

4 CHAIRMAN SEWELL: I vote yes based on
5 staff report.

6 MR. ROATE: Thank you. That's 5 votes in
7 the affirmative.

8 CHAIRMAN SEWELL: Thank you.

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1 CHAIRMAN SEWELL: Next project is C-08,
2 No. E-046-19, HSHS St. Elizabeth's Hospital in
3 O'Fallon.

4 May I have a motion to approve this
5 project to discontinue a 16-bed comprehensive
6 physical rehabilitation category of service.

7 MEMBER SLATER: I make a motion.

8 CHAIRMAN SEWELL: Is there a second?

9 MEMBER MURRAY: Second.

10 CHAIRMAN SEWELL: Would you introduce
11 yourself and be sworn in.

12 MS. BALLANCE: I'm Amy Ballance. I'm the
13 vice president for business development strategy
14 and marketing for Southern Illinois Division of
15 Hospital Sisters Health System.

16 MS. TINDALL: Hi, I'm Alison Tindall,
17 executive director of business development and
18 clinical service lines for HSHS.

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

21 (Two witnesses sworn.)

22 THE COURT REPORTER: Thank you.

23 CHAIRMAN SEWELL: State agency report.

24 MR. CONSTANTINO: Thank you, Mr. Chairman.

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1 The hospital is asking the Board to
2 approve the discontinuation of a 16-bed
3 comprehensive physical rehabilitation category of
4 service in O'Fallon, Illinois.

5 The reason for discontinuation is the
6 State Board's approval at the December 2019 Board
7 meeting of Anderson Rehabilitation Hospital in
8 Edwardsville and the hospital's own declining
9 census for this service.

10 No public hearing was requested, and no
11 letters of support or opposition were received by
12 the Board.

13 There is no cost to the discontinuation,
14 and the expected completion date has been changed,
15 which they notified us is now November 25th, 2019.

16 Thank you, sir.

17 CHAIRMAN SEWELL: Do you have a presentation?

18 MS. BALLANCE: We do have remarks to make.

19 Our certificate of exemption permit
20 application proposes to discontinue the 16 rehab
21 beds and will redesignate those beds as medical/
22 surgical and ICU beds.

23 Since our move to O'Fallon, St. Elizabeth's
24 has experienced high admission rates and continued

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1 levels of peak census. While this continued
2 utilization supports the need for health care
3 services, the increased need for additional
4 med/surg and ICU beds has also often caused delays
5 in patient throughput and declines in patient and
6 provider satisfaction.

7 To arrive at a solution, we have worked
8 with our local board of directors and key members
9 of our medical staff to evaluate options for
10 additional bed capacity. With the announcement
11 that Anderson Hospital planned to move their
12 20-bed acute rehabilitation unit to a freestanding
13 facility as well as add an additional 14 acute
14 rehabilitation beds, St. Elizabeth's anticipated a
15 significant impact on patient volumes within this
16 unit. With the sustained need to add beds for
17 medical/surgical patients, our key partners agreed
18 that discontinuing the rehabilitation service and
19 redesignating those beds to increase the number of
20 medical/surgical beds to 12 and intensive care
21 beds by 4 was the best option. The additional
22 beds at Anderson Hospital will also ensure that
23 patients in need of these services will have
24 appropriate access to care they need.

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1 Our permit application proposes to
2 discontinue the acute rehab beds and redesignate
3 the 12 of those beds as medical/surgical and
4 remaining 4 to the intensive care beds. The
5 discontinuation of the acute rehabilitation unit
6 will not affect access to care for patients due to
7 the addition of the acute rehabilitation beds
8 within the same market area.

9 Thank you for your consideration.

10 CHAIRMAN SEWELL: What was your original
11 date of implementation, and why did you change it?

12 MS. BALLANCE: The original date was set
13 towards the end of December -- January 1st.
14 However, when we were placed on -- and we
15 anticipated to be presenting at the December agenda
16 given when we submitted our application, and when
17 we moved up to this October date, we had requested
18 the accelerated deadline date.

19 CHAIRMAN SEWELL: Any questions by Board
20 members?

21 (No response.)

22 CHAIRMAN SEWELL: Roll call.

23 MR. ROATE: Thank you.

24 Motion made by Mr. Slater; seconded by

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1 Dr. Murray.

2 Dr. Martell.

3 MEMBER MARTELL: I vote in support based
4 on staff report and the redesignation events.

5 MR. ROATE: Thank you.

6 Dr. Murray.

7 MEMBER MURRAY: Yes, based on staff report.

8 MR. ROATE: Thank you.

9 Ms. Savage.

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

12 MR. ROATE: Thank you.

13 Mr. Slater.

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

16 MR. ROATE: Thank you.

17 Chairman Sewell.

18 CHAIRMAN SEWELL: Vote yes based on staff
19 report.

20 MR. ROATE: Thank you.

21 That's 5 votes in the affirmative.

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1 CHAIRMAN SEWELL: Next project is C-09,
2 Project No. E-047-19, St. Bernard Hospital in
3 Chicago.

4 May I have a motion to approve this
5 project to discontinue a 6-bed pediatric category
6 of service?

7 MEMBER SAVAGE: So moved.

8 CHAIRMAN SEWELL: Is there a second?

9 MEMBER MURRAY: Second.

10 CHAIRMAN SEWELL: Will you introduce
11 yourself.

12 MR. HOLLAND: Good morning. My name is
13 Charles Holland, H-o-l-l-a-n-d. I'm president and
14 CEO of St. Bernard Hospital.

15 MR. AXEL: I remain Jack Axel, Axel &
16 Associates.

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

19 (One witness sworn.)

20 THE COURT REPORTER: Thank you.

21 CHAIRMAN SEWELL: State agency report.

22 MR. CONSTANTINO: Thank you, Mr. Sewell.

23 The hospital is asking the Board to
24 approve the discontinuation of a 6-bed pediatric

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1 category of service in Chicago, Illinois.

2 The reason for the discontinuation is the
3 hospital's low census for this service.

4 No public hearing was requested, and no
5 letters of support or opposition were received by
6 the Board.

7 There's no cost to the discontinuation,
8 and the expected completion date is November 30th,
9 2019. The applicants have submitted all the
10 information required by the Board.

11 CHAIRMAN SEWELL: Is there a presentation?

12 MR. HOLLAND: No, there's no presentation.

13 I'd be happy to answer any questions you might have.

14 CHAIRMAN SEWELL: Are there questions by
15 Board members or comments?

16 (No response.)

17 CHAIRMAN SEWELL: Roll call.

18 MR. ROATE: Thank you, sir.

19 Motion made by Ms. Savage; seconded by
20 Dr. Murray.

21 Dr. Martell.

22 MEMBER MARTELL: Vote in support based on
23 the report.

24 MR. ROATE: Thank you.

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1 Dr. Murray.

2 MEMBER MURRAY: I vote yes based on staff
3 report.

4 MR. ROATE: Thank you.

5 Ms. Savage.

6 MEMBER SAVAGE: I vote yes based on staff
7 report.

8 MR. ROATE: Thank you.

9 Mr. Slater.

10 MEMBER SLATER: Based on staff report, yes.

11 MR. ROATE: Thank you.

12 Chairman Sewell.

13 CHAIRMAN SEWELL: Yes, based on staff
14 report.

15 MR. ROATE: Thank you.

16 That's 5 votes in the affirmative.

17 CHAIRMAN SEWELL: Thank you.

18 MR. HOLLAND: Thank you.

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1 CHAIRMAN SEWELL: There are no alteration
2 requests. There are no declaratory rulings/other
3 business. There's nothing under the Health Care
4 Worker Self-Referral Act, and there's no status
5 report on conditional/contingent permits.

6 All right. We're going to take a
7 five-minute break, but we'll be back in
8 five minutes.

9 Were going to vote to go back into executive
10 session. Is there a motion to go into closed
11 session pursuant to Section 2(c)(1), 2(c)(5),
12 2(c)(11), and 2(c)(21) of the Open Meetings Act?

13 MEMBER SAVAGE: So moved.

14 CHAIRMAN SEWELL: Second.

15 MEMBER MURRAY: Second.

16 CHAIRMAN SEWELL: All in favor, aye.

17 (Ayes heard.)

18 (At 11:25 a.m. the Board adjourned into
19 executive session. Open session proceedings
20 resumed at 11:42 a.m. as follows:)

21 CHAIRMAN SEWELL: I want to entertain a
22 motion to refer MetroSouth Medical Center; that's
23 Project No. E-024-19 to legal.

24 MEMBER SLATER: I move we refer to legal.

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1 CHAIRMAN SEWELL: Is there a second?

2 MEMBER MURRAY: Second.

3 CHAIRMAN SEWELL: All in favor say aye.

4 (Ayes heard.)

5 CHAIRMAN SEWELL: Opposed.

6 (No response.)

7 CHAIRMAN SEWELL: I want to entertain a
8 motion to refer AMITA Health St. Francis, E-040-19,
9 to legal.

10 MEMBER SAVAGE: So moved.

11 CHAIRMAN SEWELL: Is there a second?

12 MEMBER SLATER: Yes.

13 CHAIRMAN SEWELL: All in favor, aye.

14 (Ayes heard.)

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1 CHAIRMAN SEWELL: Now we are looking at
2 applications subsequent to initial review.

3 The first one is H-01, Project No. 19-017,
4 Skin Cancer Surgery Center in O'Fallon. May I
5 have a motion to approve this project to establish
6 a single-specialty ambulatory surgery treatment
7 center?

8 MEMBER SAVAGE: So moved.

9 CHAIRMAN SEWELL: Is there a second?

10 MEMBER MARTELL: Second.

11 CHAIRMAN SEWELL: Could you identify
12 yourselves and be sworn in.

13 DR. MCGINNESS: My name is Jamie
14 McGinness, J-a-m-i-e M-c-G-i-n-n-e-s-s.

15 MR. PARKHURST: Ed Parkhurst,
16 P-a-r-k-h-u-r-s-t.

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

19 (Two witnesses sworn.)

20 THE COURT REPORTER: Thank you.

21 CHAIRMAN SEWELL: State agency report.

22 MR. CONSTANTINO: Thank you, Chairman Sewell.

23 The applicants propose a single-specialty
24 ASTC in O'Fallon, Illinois, at a cost of

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1 approximately \$1.3 million. The expected completion
2 date is June 17th, 2021.

3 We did receive letters of support, no
4 letters of opposition. There was no public
5 hearing requested.

6 This application was modified on
7 September 17, 2019, to add a coapplicant. This is
8 considered a Type A modification. There was no
9 increase in the cost or the gross square footage,
10 and the scope of the project remains unchanged as
11 part of this modification.

12 We did have -- I will have to point out to
13 the Board we did have findings related to this
14 project, but we do have one change. The bank --
15 we did receive a bank letter from Carrollton Bank
16 that did provide assurance should you approve this
17 project that the loan for \$1.3 million will be
18 made.

19 Thank you, sir.

20 CHAIRMAN SEWELL: All right. Do you have
21 a presentation?

22 DR. MCGINNESS: I do, yes.

23 Good afternoon. My name is Jamie
24 McGinness. I'm a solo practice dermatologist with

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1 subspecialty training in Mohs micrographic
2 surgery. We'll talk more on this in a minute.

3 To the best of my knowledge, I'm the only
4 fellowship-trained Mohs surgeon serving the metro
5 east Illinois area. I was originally in Springfield
6 and moved to the area to be closer to home, as
7 well as the need in the area. With me here today
8 is Ed Parkhurst, our CON consultant, and I'd like
9 to thank the review board for the follow-up
10 questions and assistance in clarifying certain
11 portions of the permit application.

12 The permit application seeks approval to
13 establish a single-room, single-specialty, self-
14 contained ASTC in support of my solo office
15 practice. To meet both the Illinois licensing and
16 Medicare compliance requirements, the ASTC must be
17 self-contained and not part of my private medical
18 facility.

19 Let me quickly describe the Mohs procedure
20 and why an ASTC environment in contrast to an
21 office-based environment for select but not all
22 Mohs surgical procedures is superior and best
23 practice.

24 So Mohs surgery is the gold standard for

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1 removing skin cancers. It leads to superior cure
2 rates approaching 99 percent with superior
3 conservation of healthy tissue and excellent
4 cosmetic results. It involves treating skin
5 cancers as follows:

6 The Mohs surgery first removes the visible
7 tumor. A thin layer of normal tissue is removed,
8 grossed, and mapped. The issue is processed in
9 the Mohs laboratory on-site, cut and placed on
10 microscopic slides to evaluate 100 percent of the
11 surgical margin. The tissue is read by the Mohs
12 surgeon underneath the microscope for cancerous
13 cells. If cancerous cells are seen, further
14 tissue is removed, and this process is repeated
15 until the cancer is removed.

16 The defect is then surgically repaired
17 either in the office setting for minor procedures
18 or ideally in a surgical setting for more advanced
19 reconstructive procedures.

20 In order to efficiently perform Mohs surgery
21 in the highest quality physical environment, it
22 requires me to quickly move from my office to an
23 ASC and back. This integral clinical delivery
24 process demonstrates the necessity of physically

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1 locating the physician office contiguous with an
2 ASC not only for the highest quality patient care
3 but also to optimize efficiency for patient care.
4 Due to this delivery process and how Mohs surgery
5 is performed, the use of an ASC or hospital
6 setting in a separate location to my private
7 practice is not the best practice, efficient, or
8 convenient for the patient.

9 Several differences exist between office
10 space surgery procedures and ASC surgery procedures
11 that lends the ASCs to be the best surgical
12 practice environment for select repairs, such as
13 complex closures, flaps, and graphs. The high
14 standards associated with licensed ASCs improve
15 patient care and safety and offer advantages over
16 office-based surgery including the following:

17 The regulation requirements and licensing
18 oversight of ASCs in contrast to physician
19 offices. Office-based surgery is largely
20 unregulated. The regulation of ASCs establishes
21 uniform minimum requirements and standards which
22 are designed to reduce the variation in practice
23 patterns and improve adherence to best practices,
24 let alone the overarching surgery environment

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1 requirements in a licensed ASC.

2 The credentialing and peer review of
3 ASC surgeons in contrast to office-based surgeons
4 whom are generally not subject to detailed
5 credential review.

6 The improved surgical outcomes for all
7 comprehensive Mohs surgical procedures.

8 Lower infection rates which lead to higher
9 quality of care.

10 The improved quality of care and patient
11 safety.

12 The higher required procedural standards
13 and fewer potential errors and complications from
14 the strict operational and clinical policies and
15 procedures to ensure oversight of all aspects of
16 patient care.

17 The highly trained staff, quality
18 improvement standards, and these sites are peer
19 reviewed by visits from Medicare and the State of
20 Illinois often unannounced to ensure the
21 compliance of these policies and procedures and
22 adherence to these regulations.

23 So in summary, an ASC provides the highest
24 quality facility and best practice conditions in

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1 order ensure the highest quality patient care and
2 safety. Bottom line, I seek this to offer my
3 patients that high quality care, that high patient
4 safety that they deserve.

5 Now let me hand it over to Mr. Parkhurst
6 to address the State agency report.

7 MR. PARKHURST: Thank you, Dr. McGinness.

8 The permit application, as you'll see from
9 the State agency report, addressed 22 criteria,
10 and there were three groups that have identified
11 noncompliance issues.

12 One was project square foot and the space
13 allocation. Another was a projected demand and
14 utilization, and the third was the financing and
15 financial viability. And I think you just heard
16 from Mr. Constantino, I think we've covered that,
17 and, in fact, with the new letter from the bank
18 that's been submitted, the project will be
19 financed if, in fact, it's approved by this Board.

20 Before addressing these technical issues,
21 however, I think it important to note there are
22 very -- there are a few strong positives in
23 support of the related ASTC and proposed skin
24 cancer procedures. There's no ASTC that we're

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1 aware of -- and it's stated in staff report --
2 within the GSA that currently provides the
3 proposed Mohs surgical procedures that, in fact,
4 Dr. McGinness will perform. It also notes that
5 service accessibility and access for skin cancer
6 procedures within the service area will be
7 improved if, in fact, this particular single-
8 specialty ASTC is approved. There's a market
9 deficit today for these procedures within this
10 geographic area around the proposed location.

11 So access, in fact, for skin cancer
12 procedures will be improved. And I think
13 Dr. McGinness indicated one of the reasons he
14 moved his practice from Springfield down to the
15 O'Fallon area is because there was a deficit --
16 there was a need and a deficit of access to these
17 particular procedures within this geographic area.
18 I'm sure we've discussed this before.

19 What's also important given the criteria
20 that the Board has, there's no proposed duplication
21 of services if the project is approved, there's no
22 maldistribution of services if the project is
23 approved, and the office-based location and the
24 development of ASTC will have no impact on

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1 existing ASTCs or hospitals within the area, and
2 this is all noted within the staff report.

3 So, in other words, the proposed single-
4 room, single-specialty ASTC will have no impact on
5 the existing market and will, in fact, improve
6 access for the Mohs skin cancer procedures within
7 the defined geographic area.

8 Let me first talk about the project size.
9 If you look at your criteria, the Review Board
10 only has criteria basically for clinical area with
11 the exception of ASTCs. This particular project
12 in terms of the square footage includes both
13 clinical and nonclinical area for the ASTC. If
14 you begin to look at your criteria, they're
15 modified -- and been through this before with
16 Board legal counsel about how much or what square
17 footage needs to be included in the actual
18 definition for ASTCs. There's no excess space
19 within the ASTCs, no space within the ASTC that is
20 above what is required for licensing.

21 In this particular case with ASTCs you
22 need to profile both the clinical and nonclinical
23 rooms and spaces that are required for licensing
24 and also Medicare compliance, and that's what's in

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1 the application. And this is, in fact, one of the
2 reasons why the square footage is above your
3 criteria. And I'm sure there may be questions in
4 this regard.

5 Secondly, on utilization and demand.
6 Dr. McGinness' practice is office based. He does
7 not refer to hospitals nor does he practice in a
8 hospital. By your rules office-based utilization
9 is not considered to be one of the factors to be
10 used for actual utilization within the ASTC.

11 Given that, the actual market analysis
12 that is in the permit application demonstrates the
13 need for this particular service. It just so
14 happens Dr. McGinness is providing these procedures
15 in an existing office at the present time, but the
16 market demand is there. And I think that clearly
17 the staff report indicates that, in fact, the
18 market is there for these particular procedures.
19 And what Dr. McGinness will be providing is
20 actually improved access for the Mohs skin cancer
21 surgical procedures.

22 The third grouping of deficiencies is the
23 financing and viability. I think you've already
24 heard that financing is approved. In fact, the

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1 project is approved by the Board. Secondly, with
2 debt service coverage, the analysis, which is in
3 the supplemental material that was submitted, had
4 pro forma financial projections for six years, the
5 first year, 2021 being the start-up year. The
6 Review Board criteria for debt service coverage is
7 greater than 1.75. This criteria has been met for
8 five of the six years. It's only in the first
9 partial year of operation that the debt service
10 coverage is not covered.

11 The next financial ratio that the Board
12 has is cushion ratio. The cushion ratio is
13 included as a basis to measure if a business debt
14 obligation can be met. This viability ratio is
15 just one that the Board has. Given other projected
16 financial ratios that have been provided, days
17 cash on hand which exceeds the State Board
18 standard by 108 days, that service coverage ratio
19 is greater than what is required by the Board, and
20 because of these reasons we believe the project
21 overall is financially viable.

22 Thank you for your attention, and we're
23 now available for the Board questions.

24 CHAIRMAN SEWELL: I have questions from

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1 staff -- for staff.

2 Your finding based on financial viability,
3 I want to make sure I understand this. So this
4 applicant could not send you all the years that
5 were presented because they're a new entity?

6 MR. CONSTANTINO: They couldn't provide us
7 any historical information for the LLC because it
8 was a new entity.

9 I would like to compliment the applicants.
10 They provided us with an excellent pro forma. For
11 five years it was excellent. I think the Board
12 deserves that type of response to the financial
13 viability from all applicants that come before you
14 with a new entity. It was excellent. Why they
15 didn't meet some of the financial ratio criteria,
16 that happens.

17 CHAIRMAN SEWELL: So we don't say that
18 because they're a new entity the criterion doesn't
19 apply?

20 MR. CONSTANTINO: No.

21 CHAIRMAN SEWELL: We go ahead and make a
22 finding and then explain it?

23 MR. CONSTANTINO: Yes.

24 CHAIRMAN SEWELL: I see. Do you have any

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1 comments on their testimony about the size of the
2 project?

3 MR. CONSTANTINO: In the statute it says
4 we do not have any -- how to phrase this -- we
5 only review clinical areas, the Board. We can't
6 review nonclinical areas.

7 In this case Mr. Parkhurst is correct,
8 what will be licensed is that entire gross square
9 footage. Licensure and Medicare requires it.
10 Mr. Parkhurst is correct.

11 CHAIRMAN SEWELL: And I would ask the
12 applicant -- I want to make sure I understand what
13 you're saying with respect to the service demand
14 criteria that was not met.

15 This is an office-based practice that you
16 were the clinician for, and it's moving into an
17 ambulatory surgery treatment center framework.
18 And as an office-based practice, you didn't make
19 referrals to other ambulatory surgery treatment
20 centers?

21 DR. MCGINNESS: Correct.

22 CHAIRMAN SEWELL: Is that a correct
23 understanding that I have?

24 MR. PARKHURST: That is correct. And I

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1 think there's another important point, and
2 Dr. McGinness can talk about the total number of
3 Mohs procedures that he does. Some of those
4 procedures -- and I've learned a lot, by the way.
5 some of those Mohs procedure will continue to be
6 done in the office-based because the environment
7 lends itself to it. There's only a certain portion
8 of the current and potentially future Mohs surgery
9 procedures which will move into the ASTC. And
10 these are the more complex procedures in terms of
11 graphs, or reconstruction surgery, different types
12 of more advanced surgery procedures that, in fact,
13 Dr. McGinness can talk about because I'm clearly
14 not a clinical person.

15 The total volume that is projected of all
16 of the procedures that he does in terms of Mohs
17 procedures, I'm trying to remember, 350 in the
18 first year and 880 procedures in the subsequent
19 years.

20 And right now, Dr. McGinness, how many
21 Mohs procedures do you do on an annual basis?

22 DR. MCGINNESS: Annually in our first year
23 we had 1100 Mohs procedures. All of those weren't
24 reconstructive. Some required immediate closures

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1 which, again, were fine for an office setting, but
2 a large percentage of those did require advanced
3 reconstructive techniques, cartilage grafting,
4 forehead flaps, complex closures, skin grafts,
5 et cetera.

6 We're on pace this year for it'll probably
7 end up being approximately 1400 cases, and we just
8 continue to grow. So the demand is extremely high
9 in the area.

10 CHAIRMAN SEWELL: Questions by Board
11 members.

12 MEMBER MURRAY: I have a question. So in the
13 staff report it says that there are two hospitals
14 in this GSA that have the capacity to provide these
15 services. Do you know if they are providing these
16 procedures?

17 MR. PARKHURST: As far as we know, there's
18 no publicly available information as to the Mohs
19 procedures that could potentially be done. And I
20 think to answer your question in a little more
21 detail, what Dr. McGinness described I think a
22 little earlier is the way the Mohs procedures are
23 done in terms of procedurals.

24 Partly they're done within the physician

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1 office, and then immediately thereafter, if, in
2 fact, there needs to be reconstruction or more
3 advanced surgery, those procedures would move into
4 the ASTC, which is integral with the office-based
5 practice but, in fact, has to be freestanding by
6 Medicare regulations and Illinois licensing.

7 So on a daily basis Dr. McGinness actually
8 moves between the office practice and what
9 procedures can be done within the office into the
10 ASTC when patients, in fact, need the more
11 advanced surgery in a surgical environment best
12 practice to maintain quality and safety of those
13 select patients.

14 So it's an operational -- no pun intended,
15 it's an operational procedure, if you will, in
16 terms of how the clinical practice is. And if, in
17 fact -- you know, you can move across the street
18 or 2 miles away to surgery. It may be potentially
19 feasible to do that, but in terms of a practical
20 sense, the patient care sense, moving a patient
21 that may have an incision really is not a very
22 safe or quality way to practice the Mohs surgery
23 procedures.

24 MEMBER MURRAY: I wasn't really asking

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1 about that. I know you said earlier that you
2 were, as far as you know, the only person with
3 fellowship training in this area. I was really
4 just curious of whether you were aware of any
5 other dermatologists in these two hospitals that
6 might be performing some of these procedures
7 within the hospital setting.

8 DR. MCGINNESS: Not that I'm aware of.
9 Most of my referrals come from the dermatologists
10 in the area, and if Mohs is needed, they refer to
11 me. I can't -- I'm trying to think of if there's
12 any I'm not aware of. Mostly if surgery is needed
13 in the area, it's referred in to me.

14 MEMBER SAVAGE: If I can tack onto that
15 question. With the Mohs procedure -- obviously, I
16 know what that is, but what is the reason that
17 it's not done in the hospital typically.

18 DR. MCGINNESS: The reason it's not done
19 in the hospital you mean like in an OR?

20 MEMBER SAVAGE: Right.

21 DR. MCGINNESS: The Mohs procedure itself
22 doesn't require an OR or need an OR as far as
23 removal goes, an office-based setting is
24 completely acceptable. It's just the advanced

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1 reconstructions. And as far as I'm aware,
2 Medicare wouldn't cover an OR for Mohs surgery.

3 Beyond that, Mohs-specific laboratory is
4 needed, a certified laboratory on-site which is
5 also within the office setting.

6 CHAIRMAN SEWELL: Other questions by Board
7 members?

8 (No response.)

9 CHAIRMAN SEWELL: Roll call.

10 MR. ROATE: Thank you.

11 Motion made by Ms. Savage; seconded by
12 Dr. Martell.

13 Dr. Martell.

14 MEMBER MARTELL: I vote yes based on the
15 testimony and the report.

16 MR. ROATE: Thank you.

17 Dr. Murray.

18 MEMBER MURRAY: I vote yes based on the
19 testimony and the staff report.

20 MR. ROATE: Thank you.

21 Ms. Savage.

22 MEMBER SAVAGE: I vote yes based on the
23 staff report and testimony.

24 MR. ROATE: Thank you.

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1 Mr. Slater.

2 MEMBER SLATER: I vote yes based on the
3 testimony.

4 MR. ROATE: Thank you.

5 Chairman Sewell.

6 CHAIRMAN SEWELL: I vote yes. The negative
7 issues in the State agency report I think have been
8 adequately addressed or at least put in context.

9 MR. ROATE: That's 5 votes in the
10 affirmative.

11 MR. PARKHURST: Thank you very much.

12 DR. MCGINNESS: Thank you guys for your
13 time. Appreciate it.

14 CHAIRMAN SEWELL: Okay. We're going to
15 break for lunch until about 12:50.

16 (Recess taken, 12:07 p.m. to 12:56 p.m.)

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1 CHAIRMAN SEWELL: Okay. We're going to
2 come to order.

3 Next on the agenda is H-03, Project 19-027,
4 DaVita Midway Dialysis in Chicago.

5 May I have a motion to approve this
6 project to establish a 12-station end-stage renal
7 disease facility.

8 MEMBER SAVAGE: So moved.

9 CHAIRMAN SEWELL: Is there a second?

10 MEMBER MURRAY: Second.

11 CHAIRMAN SEWELL: Would you introduce
12 yourselves.

13 MS. COOPER: Good afternoon. My name is
14 Anne Cooper, counsel for DaVita, the applicant for
15 this project.

16 MS. THOMAS: I'm Dawn Thomas, director at
17 DaVita.

18 MS. FRIEDMAN: Kara Friedman, Polsinelli,
19 counsel for DaVita.

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

22 (Three witnesses sworn.)

23 THE COURT REPORTER: Thank you.

24 CHAIRMAN SEWELL: State agency report.

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1 MR. CONSTANTINO: Thank you, Mr. Chairman.

2 The applicants are asking the Board to
3 approve a 12-station ESRD facility in Chicago,
4 Illinois. The cost of the project is approximately
5 \$5.3 million. The expected completion date is
6 December 31st, 2021.

7 We did receive a comment on the State
8 Board staff report. There was no request for a
9 public hearing, and no letters of support or
10 opposition were received by the State Board.
11 There was a finding related to this project.

12 I do have those handouts if someone would
13 like to see the hard copy.

14 MS. AVERY: The ones Kara has?

15 MR. CONSTANTINO: The ones that Kara
16 submitted as a comment on State Board staff
17 report.

18 MS. COOPER: I've got copies.

19 MS. AVERY: I'll help you.

20 CHAIRMAN SEWELL: Okay. We'll let them
21 pass those out.

22 MS. COOPER: And just to clarify, we
23 actually had blown these up, but I think they got
24 left at someone's front door and didn't make it to

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1 the meeting today, so we'll ask you to look in
2 your packet at them.

3 MS. AVERY: Use your mics.

4 CHAIRMAN SEWELL: Speaking of using the
5 mics, all of us have been asked, including the
6 Board, to put the mics closer to our mouth when
7 we're speaking because people are having trouble
8 hearing. So I'm sorry about that.

9 MR. CONSTANTINO: We did send this by
10 email to you, too.

11 CHAIRMAN SEWELL: Okay. Do you have a
12 presentation?

13 MS. THOMAS: I'm Dawn Thomas, director of
14 operations over the planned DaVita Midway clinic.
15 With me today are our CON attorneys Kara Friedman
16 and Anne Cooper.

17 I'd like to thank the Board staff for its
18 thorough assessment of this planned clinic and the
19 generally positive State board report. I'd also
20 like to thank our patient advocates who took time
21 off earlier today to discuss their family
22 experiences, Ella Tate, Irma Lizcano and Romie
23 Middleton-Jackson.

24 So this planned clinic, a collaboration of

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1 University of Chicago nephrologists is designed to
2 address a portion of the need for additional
3 clinics identified by the State. As part of that
4 collaboration, DaVita operates clinics at U of C on
5 the south side neighborhoods of Stony Island,
6 Woodlawn, Kenwood, and Park Manor. Still there's
7 a need for 80 stations in the city of Chicago,
8 roughly seven clinics. This clinic will address
9 the need for one of these clinics, and we are
10 placing it in a area with a high concentration of
11 individuals suffering from kidney disease.

12 So I have a few comments, and I'm pleased
13 to share them today with the new Board members who
14 may only be anecdotally aware of the services that
15 DaVita offers.

16 First, I'd like to describe our primary
17 charge is as a kidney care provider. The
18 immediate need for our patients is dialysis, which
19 is blood filtering that replaces a kidney that no
20 longer works. Dialysis is administered to every
21 kidney failure patient who is compliant with his
22 or her treatment protocol 156 times a year.
23 That's about four hours a day, three times a week,
24 every week of every month of the year.

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1 Some of our patients can drive, but many,
2 especially poor and elderly patients rely on
3 assistance for transportation from friends, family,
4 and transportation programs. Getting to and from
5 dialysis effectively every other day is a heavy
6 lift not just for the community but for family,
7 too, which shows the relevance of access to care.

8 As a medical home for these patients we're
9 charged with renal disease population health
10 management and use evidence-based practices to
11 improve their dialysis outcomes and overall
12 health. Our patients nearly always suffer from
13 associated disease comorbidities such as
14 cardiovascular disease, diabetes or glucose
15 intolerance, hypertension, and lipid disorders.
16 With our physician partners we are on the front
17 line of managing the patient's overall well-being
18 and the associated high cost with hospitalizations
19 and other complications or a comorbidity-ill
20 patient group.

21 Leading the industry for four years running,
22 DaVita is one of the most prominent dialysis
23 providers in the country, and we are the leading
24 care provider under the CMS 5 Star quality rating

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1 system. We help kidney patients lead healthier
2 lives while improving clinical outcomes and total
3 cost of care.

4 We collaborate with Federal government on
5 many initiatives to improve patient outcomes, and
6 we are committed to:

7 One, educating the general population and
8 particularly those with diabetes and hypertension
9 who are most at risk for kidney disease about the
10 condition and what they can do to prevent its
11 progression;

12 Two, helping identify patients at the
13 early stage of kidney disease to bring in the
14 appropriate primary care and specialty physician
15 care to indefinitely maintain their kidney
16 function;

17 Three, supporting patients to get on and
18 stay on transplant list;

19 Four, educating patients on home treatment
20 modalities and ensuring their success on dialysis
21 at home;

22 And then, five, reinforcing the importance
23 of showing up for treatment with patients.

24 We promptly reschedule the patients' missed

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1 treatments, and we work hard to mitigate costly
2 hospitalizations, again, all of which correlate to
3 access to care.

4 So in my role in the Chicago clinics, I see
5 how important neighborhood access to care is in
6 getting patients to remain compliant with their
7 treatment protocol. Treatment compliance directly
8 leads to lower hospitalizations and to better
9 patient outcomes.

10 So specific to lowering hospitalization
11 rates, this is a core focus of our integrated
12 kidney care initiatives. We take a patient-centered
13 approach to managing the unique needs of medically
14 complex renal patients across the entire care team
15 and continuum. Our holistic approach is built on
16 ongoing communications with patients during their
17 treatment to address their health needs beyond
18 dialysis with hands-on care from the treating
19 nephrologist.

20 In Chicago our clinical team partners with
21 clinic managers to develop plans for frequently
22 hospitalized patients to help them manage their
23 total health care needs. These initiatives and
24 our patient compliance monitoring have resulted in

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1 lowering our hospitalizations.

2 Our existing centers in the relevant
3 service area, which is 5 miles, are all operating
4 well over the 80 percent utilization target, 90,
5 88, and 100 percent respectively. We expect this
6 area to be over 80 percent utilization by 2022,
7 which is inclusive of Midway and other clinics we
8 have recently opened. And Kara will discuss the
9 broader area trends in a moment.

10 DaVita's dedicated to expanding access for
11 patients in the City of Chicago despite the
12 difficulties we often face due to heavy reliance
13 on government programs and very few patients
14 covered by commercial insurance. With regard to
15 the location of this clinic, many parts of
16 Chicago, including this one, are economically
17 disadvantaged with significant minority
18 populations with a high chronic disease burden.

19 As shown in the visuals that we submitted,
20 comparing the ESRD population mix of the city of
21 Chicago to the remainder of the state, 63 percent
22 of the ESRD patients in Chicago are African-American
23 compared to 41 percent statewide; 23 percent of the
24 ESRD patients are Hispanic compared to 16 percent

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1 statewide. The Midway community is medically
2 underserved, which means access to key screening
3 and disease prevention resources are limited.

4 The incidence of diabetes and hypertension
5 is increasing nationally, and as outlined in our
6 application, African-American and Hispanic
7 communities like this one bear a disproportionate
8 share of the disease burden. When an individual
9 lacks access to care, diseases are poorly managed
10 and get worse more rapidly. The catastrophic
11 outcome too often faced is a patient's revelation
12 that their kidneys have failed when they present
13 in the emergency department in acute irreversible
14 renal failure.

15 As a result of a lack of access to care
16 and disease management services, it's not
17 surprising, also as depicted in the visuals that
18 we submitted which is derived from this agency's
19 analysis, that Chicago has the highest incidence
20 of dialysis use rate in the state, nearly 1.9 per
21 thousand, significantly higher than the statewide
22 use rate, which is 1.4 per thousand, and more than
23 twice the rate of HSA4 which is the planning area
24 with the lowest use rate.

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1 Thank you for your time today, and Kara
2 will address the single finding on the Board staff
3 report.

4 MS. FRIEDMAN: Thank you, Dawn.

5 One thing that Dawn mentioned when she
6 talked about the health care disparities in this
7 community. There are two designations that are
8 noted on page 7 of the Board staff report that are
9 relevant to your consideration today, and that is
10 that this is a health professional shortage area,
11 as well as a medically underserved population. And
12 those are designations that the Federal government,
13 the Health Resources and Services Administration
14 designates the community as. And based on that,
15 this placement of a clinic in this area receives a
16 more favorable consideration under your rules.

17 DaVita's application did meet all the
18 financial viability and economic feasibility
19 criteria, and of the 21 criteria there was only
20 one shortcoming identified.

21 This planning -- this state is set up into
22 11 planning areas, and the city of Chicago has its
23 own designation as a single planning area. With
24 the need formulations that came out at the last

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1 meeting, seven clinics were identified to be
2 needed in the city of Chicago. This particular
3 Midway clinic is a collaboration with the University
4 of Chicago nephrology department, and in that
5 collaboration there are already four clinics that
6 are located. And if you look at what you have in
7 your submission, this green-shaded chart, they're
8 located in the -- kind of right here in the side
9 and lower part of this chart that indicates that
10 they're located in the highest density areas of
11 patients suffering from end-stage renal disease.

12 And as you continue to look on that,
13 you'll see there's a yellow dot at the location of
14 this planned clinic. So with University Physicians
15 we're planning to add another clinic in an area
16 that also has a very high incidence of end-stage
17 renal disease.

18 And the reason we know that those patients
19 exist is because there is a Federal organization
20 called the Renal Network that tracks quality in
21 each of the various areas of the United States.
22 And the renal network over Illinois has supplied
23 this information in order for us to show you how
24 this population is disseminated over the city of

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1 Chicago.

2 As you probably know, kidney failure can
3 generally be predicted by lab values associated
4 with decreased kidney function and increased value
5 for certain blood toxins. This is how University
6 of Chicago physicians developed their list of
7 patients anticipated to require care in the next
8 couple of years, and it's based on the immediate
9 3-mile area around this facility-planned location.

10 These facilities are very small. There are
11 about -- there are over 1300 patient within a 5-mile
12 area of this clinic that are already on dialysis,
13 so that means that they need about 20 clinics in
14 that area, and that sounds like a lot. These
15 clinics kind of pop up around what you would expect
16 for a Walgreen's except they are smaller than a
17 Walgreen's location would be. So the proximity to
18 the patient's home is really critical for making
19 sure that they get there time and again and that
20 their families are able to support them to get
21 them to their treatments.

22 Here our nephrology partners identified
23 140 patients. There's only going to be 65 to
24 75 patients at this particular location. Hopefully

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1 some of those other patients will maintain their
2 kidney function, or they'll opt for a different
3 care modality for their care, or some of them
4 unfortunately will not survive. Their likelihood
5 of surviving is actually lower in this community
6 than it is in other areas of Chicago that are more
7 affluent, so particularly important we think to
8 place an additional avenue of care.

9 Most important we think for your
10 consideration about why there might be a negative
11 finding here, there is a trend of about 3 percent
12 annual growth rate of patients in this immediate
13 5-mile area, and that's a trend that's persisted
14 for four years. So if you trend out to the year
15 that this need was projected for, which is 2022,
16 with that growth rate you'll see that the overall
17 average utilization of the clinics in this area is
18 over 80 percent.

19 And then, finally, just one thing I wanted
20 to note for you. In our submission we included
21 this map of the city of Chicago that has a few
22 circles around it. So the providers have a mandate
23 to figure out where to place these clinics based
24 on where the patients are, where they're most

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1 needed, and they always have to consider where the
2 patients are, and they can also look at what
3 supply exists in other places.

4 If you had look at this map, there will
5 not be an area in the city of Chicago that doesn't
6 have at least a single clinic that's operating
7 under 80 percent. And so, for example, the other
8 application that was pending today has facilities
9 operating between 53 percent and 100 percent in their
10 area, which is up near 290 at Loretto Hospital.

11 So any project that you see before you today
12 is going to have that slight negative finding due
13 to there being some capacity in other areas, but
14 as the trend continues, we will find that those
15 facilities are more utilized and at your optimal
16 utilization by 2022, which is what we're
17 planning for.

18 Thank you for your time, and we're happy
19 to answer any questions.

20 CHAIRMAN SEWELL: Board members, any
21 questions?

22 MEMBER MURRAY: So I have a question. I
23 heard you say that, you know, you think in 2022
24 80 percent capacity will be met, and I want to be

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1 clear and maybe you can help me understand better.

2 So we're talking about a part of the city
3 that is losing population, especially
4 African-American population, and we're talking
5 about a treatment modality that is shifting to
6 home dialysis.

7 So if you could talk to me about how those
8 two trends going in the opposite direction, how
9 then can you say in 2022 everybody --

10 MS. FRIEDMAN: So I think in your
11 projection for the city of Chicago the population
12 is effectively flat. I think there was a small
13 increase of overall population. But, unfortunately,
14 the use rate in the city of Chicago is --

15 MEMBER MURRAY: I want -- I don't want to
16 get confused. So in the city of Chicago -- I'm
17 not talking about the total population for the
18 city; I'm talking about the black population on
19 the south side of Chicago is going down, so -- and
20 especially poor. To be really clear, the poor
21 people of the city of Chicago has been going down
22 for 25 years.

23 So the population that you're targeting here
24 is moving out of the city and -- obviously,

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1 everybody is not going to move -- and in addition
2 to that, more and more people are going to be using
3 home dialysis rather than dialysis at a center.

4 So I'm trying to understand how, given
5 those two important trends, you can still say that
6 you're not -- this lack of -- the fact that
7 everybody is under capacity is something we
8 shouldn't worry about.

9 MS. FRIEDMAN: So that 3 percent figure
10 that I provided you is the clinics that are
11 located in this Midway area and out to 5 miles.
12 Those are the ones that the State Board staff
13 report is grading against, and that's where that
14 3 percent increase is being seen.

15 Certainly, home modalities are favored,
16 and in some communities they are trending up.
17 When you don't have good community support, when
18 you don't have the financial means to do some
19 things necessary to maintain dialysis, you might
20 have some bias towards having a health care
21 provider assist you with your service in a setting,
22 and we have found some of that -- some of you were
23 here for the presentation offered to us several
24 months ago -- I think it was January -- about the

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1 difficulty patients are facing in selecting home
2 dialysis.

3 So as much as DaVita has many initiatives
4 to improve home dialysis utilization, I think it's
5 still a struggle for some patients to accept that
6 that's the right modality for them, and patients
7 always have a choice of modality.

8 CHAIRMAN SEWELL: Any other questions or
9 comments?

10 (No response.)

11 CHAIRMAN SEWELL: Roll call.

12 MR. ROATE: Motion made by Ms. Savage;
13 seconded by Dr. Murray.

14 Dr. Martell.

15 MEMBER MARTELL: I vote no in reviewing
16 the staff report and the testimony provided.

17 MR. ROATE: Thank you.

18 Dr. Murray.

19 MEMBER MURRAY: Based on the testimony and
20 the staff report I vote no.

21 MR. ROATE: Thank you.

22 Ms. Savage.

23 MEMBER SAVAGE: I vote no based on the
24 testimony and the staff report.

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1 MR. ROATE: Thank you.

2 Mr. Slater.

3 MEMBER SLATER: No, based on the staff
4 report.

5 MR. ROATE: Thank you.

6 Chairman Sewell.

7 CHAIRMAN SEWELL: I vote no based on that
8 one criterion.

9 MR. ROATE: Thank you.

10 That's 5 votes in the negative.

11 MS. AVERY: You have received an intent
12 deny and I will follow it up.

13 MS. FRIEDMAN: Thank you.

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1 CHAIRMAN SEWELL: Next on the agenda is
2 H-04, Project No. 19-033, Fresenius Medical Care
3 in Skokie.

4 May I have a motion to approve this
5 project to establish a 14-station end-stage renal
6 disease facility.

7 MEMBER SLATER: I move for approval.

8 CHAIRMAN SEWELL: Is there a second?

9 MEMBER MARTELL: I second.

10 CHAIRMAN SEWELL: Could you introduce
11 yourselves and be sworn in.

12 MS. WRIGHT: Lori Wright, CON specialist
13 for Fresenius Medical Care.

14 MS. WIEKIERAK: Good afternoon. I'm
15 Mary Beth Wiekierak, vice president of Fresenius.

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

18 (Two witnesses sworn.)

19 THE COURT REPORTER: Thank you.

20 CHAIRMAN SEWELL: State agency report.

21 MR. CONSTANTINO: Thank you, Mr. Chairman.

22 The applicants are asking the Board to
23 approve the relocation of a 14-station ESRD facility
24 in Skokie to another location approximately

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1 1.8 miles and six minutes from its current site at
2 a cost of approximately \$8.2 million. The expected
3 project completion date is September 30th, 2021.
4 No new stations are being added to the excess of
5 127 stations in this planning area.

6 According to the applicants, the existing
7 site is old, and the lease is expired by
8 January 31st, 2021, with no renewal option.

9 There was no public hearing, and no
10 support or opposition letters were received by the
11 State Board. All the current patients are
12 expected to transfer to the relocated facility
13 should you approve this project.

14 Thank you, Mr. Sewell.

15 CHAIRMAN SEWELL: Is there a presentation?

16 MS. WRIGHT: No. This is a simple
17 relocation that meets all your criteria. We'd be
18 happy to answer any questions you may have.

19 CHAIRMAN SEWELL: Board members have
20 questions or comments?

21 (No response.)

22 CHAIRMAN SEWELL: Roll call.

23 MR. ROATE: Thank you, sir.

24 Motion made by Mr. Slater; seconded by

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1 Dr. Martell.

2 Dr. Martell.

3 MEMBER MARTELL: Yes for the relocation
4 based on the staff report.

5 MR. ROATE: Thank you.

6 Dr. Murray.

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

9 MR. ROATE: Thank you.

10 Ms. Savage.

11 MEMBER SAVAGE: Yes, based on the staff
12 report.

13 MR. ROATE: Thank you.

14 Mr. Slater.

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

17 MR. ROATE: Thank you.

18 Chairman Sewell.

19 CHAIRMAN SEWELL: Yes, based on the staff
20 report.

21 MR. ROATE: Thank you.

22 That's 5 votes in the affirmative.

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1 CHAIRMAN SEWELL: Next project is H-05,
2 Project No. 19-034, Fresenius Medical Care
3 Des Plaines.

4 May I have a motion to approve this
5 project to add 3 stations to an existing
6 13-station ESRD facility.

7 MEMBER SAVAGE: So moved.

8 CHAIRMAN SEWELL: Is there second?

9 MEMBER SLATER: Second.

10 CHAIRMAN SEWELL: State agency report.

11 MR. CONSTANTINO: Thank you, Mr. Chairman.

12 The applicants are asking the Board to
13 approve the addition of 3 ESRD stations to an
14 existing 13-station facility in Des Plaines. The
15 cost of the project is approximately \$488,000.
16 The expected completion date is March 31st, 2021.

17 The applicants have averaged 79 percent
18 utilization over the past 12 months and 77 percent
19 utilization over the past 24 months.

20 For an expansion or an increase in stations
21 for an existing facility, the station need or
22 excess is not considered in the evaluation.

23 We have one finding related to the
24 reasonableness of the modernization cost.

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1 No public hearing was requested and no
2 letters of support or opposition were submitted to
3 the State Board.

4 Thank you, sir.

5 CHAIRMAN SEWELL: Presentation.

6 MS. WRIGHT: Yes. This, again, is just a
7 simple addition of three stations. This facility
8 had a station added last June, and still it remains
9 at 79 percent utilization, so we want to add the
10 other three stations that we have the space for.

11 The one negative in the report is the
12 reasonableness of project costs, and it's for the
13 construction which is over the State standard, and
14 this is because this is a major construction
15 project. We're removing a conference room, a
16 lounge, office space and repurposing it for part
17 of the treatment floor. So with that there's kind
18 of high-dollar line items, such as floor, doors,
19 cabinetry, new nurses' station. Normally these
20 costs are spread over the entirety of a clinic when
21 we build one. However, this is just attributed to
22 the expansion space, so it appears higher.

23 Other than that, we'd be happy to answer
24 any questions.

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1 CHAIRMAN SEWELL: I want to make sure I
2 understand your statement here in the report.

3 So the area that's being renovated is
4 where the focus of these costs are, and in that
5 area you have items -- and you gave examples here,
6 cabinetry, flooring, doorways, walls, and a
7 nurses' station. It's very focused in that area,
8 and that's why the State standard is exceeded in
9 terms of cost; is that correct?

10 MS. WRIGHT: Correct. Correct.

11 CHAIRMAN SEWELL: Okay. Questions by
12 Board members or comments?

13 MEMBER MURRAY: I just have a question
14 really for staff. How often do we adjust our
15 dollar standards for the construction costs?

16 MR. ROATE: Our cost standards are
17 adjusted quarterly per RSMeans.

18 MEMBER MURRAY: Thank you.

19 CHAIRMAN SEWELL: Okay. Doesn't sound
20 like there are any other questions -- oh, I'm sorry.

21 MEMBER MARTELL: Clarification. So the
22 costs are related to both the modernization of the
23 entire facility in addition to the additional
24 stations?

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1 MS. WRIGHT: No, the cost is just for the
2 927 gross square feet that we are modernizing.

3 CHAIRMAN SEWELL: So it sounds like a small
4 denominator because the renovation is focused on a
5 small area.

6 MS. WRIGHT: Smaller area but we're
7 tearing down walls.

8 CHAIRMAN SEWELL: And within that you're
9 doing a lot of stuff.

10 MS. WRIGHT: A lot of expensive things, yes.

11 CHAIRMAN SEWELL: Okay. Roll call.

12 MR. ROATE: Thank you, sir.

13 Motion made by Ms. Savage; seconded by
14 Mr. Slater.

15 Dr. Martell.

16 MEMBER MARTELL: Yes, based on the staff
17 report and the testimony provided.

18 MR. ROATE: Thank you.

19 Dr. Murray.

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

22 MR. ROATE: Thank you.

23 Ms. Savage.

24 MEMBER SAVAGE: Yes, based on the

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1 testimony and staff report.

2 MR. ROATE: Thank you.

3 Mr. Slater.

4 MEMBER SLATER: Based on the staff report
5 and the testimony, yes.

6 MR. ROATE: Thank you.

7 Chairman Sewell.

8 CHAIRMAN SEWELL: Yes, based on the
9 testimony.

10 MR. ROATE: Thank you.

11 That's 5 votes in the affirmative.

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1 CHAIRMAN SEWELL: Next is H-06, Project
2 No. 19-035, Fresenius Medical Care in Jackson Park.

3 May I have a motion to approve this
4 project to add 2 ESRD stations and discontinue or
5 reestablish a 24-station ESRD facility.

6 MEMBER SAVAGE: So moved.

7 CHAIRMAN SEWELL: Is there a second?

8 MEMBER MARTELL: Second.

9 CHAIRMAN SEWELL: State agency report.

10 MR. CONSTANTINO: Thank you, Mr. Chairman.

11 The applicants are asking the Board to
12 approve the relocation of a 24-station ESRD facility
13 which is approximately -- which will be approximately
14 four minutes from the current site, which is at
15 the Jackson Park Hospital, at a cost of
16 approximately \$7.5 million.

17 The reason for the relocation is the age
18 of the existing space, approximately 41 years, and
19 the difficulty in accessing the current site. No
20 new stations are being added. All current patients
21 are expected to transfer to the new clinic.

22 No public hearing was requested, and the
23 Board did not receive any support or opposition
24 letters. The estimated completion date is

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1 December 31st, 2021.

2 Thank you, sir.

3 CHAIRMAN SEWELL: All right. Is there a
4 presentation?

5 MS. WRIGHT: Again, this project meets all
6 your criteria, so we'd be happy to answer any
7 questions.

8 CHAIRMAN SEWELL: Are there questions?

9 MEMBER SLATER: How close are these two
10 locations.

11 MS. WRIGHT: Half a mile away.

12 CHAIRMAN SEWELL: Any other questions?

13 (No response.)

14 CHAIRMAN SEWELL: Roll call.

15 MR. ROATE: Thank you, sir.

16 Motion made by Ms. Savage; seconded by
17 Dr. Martell.

18 Dr. Martell.

19 MEMBER MARTELL: Yes, based on staff report.

20 MR. ROATE: Thank you.

21 Dr. Murray.

22 MEMBER MURRAY: Yes, based on the staff
23 report.

24 MR. ROATE: Thank you.

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1 Ms. Savage.

2 MEMBER SAVAGE: Yes, based on the staff
3 report.

4 MR. ROATE: Thank you.

5 Mr. Slater.

6 MEMBER SLATER: Based on the staff
7 report, yes.

8 MR. ROATE: Thank you.

9 Chairman Sewell.

10 CHAIRMAN SEWELL: I vote yes based on the
11 State agency report.

12 MR. ROATE: Thank you.

13 That's 5 votes in the affirmative.

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1 CHAIRMAN SEWELL: Next on the agenda is
2 H-07, Project No. 19-037, Provident Hospital of
3 Cook County in Chicago.

4 May I have a motion to approve this
5 project for a modernization.

6 MEMBER MARTELL: So moved.

7 CHAIRMAN SEWELL: Is there a second?

8 MEMBER SLATER: Second.

9 CHAIRMAN SEWELL: Could you introduce
10 yourselves and then be sworn in.

11 DR. SHANNON: Dr. Jay Shannon, CEO of Cook
12 County Health.

13 MS. PATEL: Ameer Patel, CON counsel to
14 Cook County Health.

15 MR. MARK: Jeffrey Mark, CON consultant.

16 MS. SEATON: Tanya Seaton, operating
17 officer for Provident Hospital.

18 MR. TURNER: Arnold Turner, medial
19 director, Provident Hospital.

20 DR. KEEN: Richard Keen, surgery chair of
21 Provident Hospital.

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

24 (Six witnesses sworn.)

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1 THE COURT REPORTER: Thank you.

2 CHAIRMAN SEWELL: State agency report.

3 MR. CONSTANTINO: Thank you, Mr. Chairman.

4 The applicants are asking the Board to
5 approve the modernization of an 85-bed hospital in
6 Chicago, Illinois, at a cost of approximately
7 \$241 million.

8 Should the Board approve this project, the
9 hospital will have a total of 48 beds, 42 med/surg
10 beds and 6 ICU beds, as well as a comprehensive
11 emergency department. Currently the hospital has
12 a basic emergency department.

13 The expected completion date is April 1st,
14 2023. No public hearing was requested, and no
15 letters of opposition were received. Letters of
16 support were received by the Board.

17 I would like to point out to the Board I
18 did make a mistake -- one of many. On the 100-bed
19 medical/surgical bed requirement for this hospital,
20 that is not relevant to a modernization of a
21 hospital. It only -- it's only used when an
22 applicant is establishing a new hospital.

23 I do have -- and then there was also
24 comments to the State Board staff report that so

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1 eloquently pointed that out to me.

2 CHAIRMAN SEWELL: What does the 100-bed
3 minimum error change in the finding --

4 MR. CONSTANTINO: That finding goes
5 away, sir.

6 CHAIRMAN SEWELL: All right. Is there a
7 presentation?

8 DR. SHANNON: Good afternoon. I'm
9 Dr. Jay Shannon, CEO of Cook County Health.

10 For more than 180 years our organization
11 has been honored to carry out a mission to deliver
12 integrated health services to residents of Cook
13 County with dignity and respect regardless of the
14 ability to pay.

15 In 2017 the system provided over 1 million
16 patient encounters, including 118,000 equivalent
17 inpatient days and nearly 1,040,000 outpatient
18 visits. Those patient encounters included 145,000
19 visits through our emergency department and Level I
20 trauma center.

21 It's important to note that we often
22 provide these services to people whom no one else
23 will care for. In 2017 Cook County Health
24 provided 37 percent of all the charity care in the

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1 state of Illinois and more than half of the
2 charity care in Cook County. This is an enormous
3 responsibility but one that we take on because we
4 believe so strongly in our mission. We expect to
5 provide more than \$375 million in charity care this
6 year. This is an astounding number in a post-ACA
7 world.

8 We have -- 45 percent of the people that
9 we serve are uninsured and another 33 percent are
10 insured by Medicaid. This is a payor mix that no
11 one would like to be caring for across Cook County
12 but we're happy to do this.

13 With managed care as the predominant model,
14 we have shifted our focus away from reactive sick
15 care toward preventive and health care over the
16 past several years. This current project proposed
17 is evidence of that strategy.

18 On August the 12th we filed our formal
19 certificate of need application to construct a new
20 downsized hospital and modernized outpatient
21 facility on the Provident campus. If the CON is
22 approved, we intend to move forward with a new
23 8-story 230,000-square-foot facility that will
24 consolidate inpatient and outpatient services in a

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1 new efficient modern tower.

2 Provident first opened in 1891 as the
3 first African-American-owned hospital and would
4 later become the first nursing school for black
5 women in Chicago. Provident, as you may know, was
6 also the site historically of the first open-heart
7 surgery performed by Dr. Daniel Hale Williams, a
8 prominent African-American physician and surgeon.
9 We intend to continue the legacy of Provident
10 hospital.

11 In 1991, seeing the need for care in the
12 area, Cook County acquired Provident after it had
13 closed its doors in 1987. We spent \$50 million at
14 that time to update the facility, and it was
15 reopened in 1993. Since 1993 we've cared for
16 thousands of patients who in many cases had
17 nowhere else to go.

18 Over the years, we have retrofitted and
19 upgraded as best we could, but we're at a point
20 now where the cost to continue to retrofit and
21 upgrade the current facility no longer makes
22 sense. But there is still an important need for
23 our services in the Provident community.

24 We care for thousands of individuals who

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1 live in and around Provident, but often we have to
2 ask them to go to Stroger Hospital on the west
3 side for more complex care because the current
4 facility isn't equipped to do that, and the cost
5 to upgrade it are prohibitive. Provident, like
6 many aging facilities, requires significant
7 investment for repair and maintenance, estimated
8 in 2014 to be more than \$100 million in upgrades.

9 With a new replacement hospital, we
10 anticipate expanding the scope and scale of
11 services offered to our patients while enhancing
12 access to core primary care and preventive health
13 services for the south side of Chicago and the
14 southland of Cook County.

15 Specifically, that plan includes the
16 diversion back to the Provident campus of inpatients
17 and ambulatory patients from the Provident
18 Ketchman area who currently need to travel to the
19 west side to Stroger. We plan on expanding the
20 emergency department which today provides more
21 than 30,000 visits a year but has not been accepting
22 ambulance runs since 2011, and we plan to make
23 that a comprehensive emergency room. This will
24 certainly drive up inpatient admission and the

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1 need for inpatient days. We also plan to establish
2 new clinical services, including a GI/endoscopy
3 area, bariatric surgery, women's health, and
4 multiple surgical specialties.

5 Evaluating who would benefit through a
6 lens toward health equity helped us to shape our
7 vision for a new Provident campus. We find it
8 unacceptable that for those living in the
9 Washington Park and Brownsville area the average
10 life expectancy is more than 10 years lower than
11 it is for more affluent areas of Chicago. A new
12 modern facility will allow our health system to
13 help close these health equity gaps by providing
14 the community with the high-quality services close
15 to where it lives and that that community
16 deserves.

17 This new facility will reduce the a number
18 of Provident patients having to travel to the
19 Stroger campus by 40 to 50 percent.

20 We believe that, by improving access to
21 care and community wellness, we can ultimately
22 better the health of patients in the Provident
23 community, reduce unnecessary health care costs,
24 and, once again, contribute greatly to the entirety

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1 of the health of Cook County. Our vision is a
2 healthy county with health equity across
3 communities, a productive workforce, and a strong
4 public health infrastructure.

5 I'm proud to say that we're well on our
6 way to that vision with the vision that we've
7 shared with the Board today, and we look forward
8 to your questions.

9 MS. PATEL: My name is Ameer Patel, A-m-e-e
10 P-a-t-e-l, I'm CON counsel to Cook County Health.
11 And I wanted to just start out by thanking the
12 Board staff not only on the development of the
13 SAR but through the technical assistance they've
14 offered through this process.

15 And now I want to focus your attention on
16 two objectives that really stand out with this
17 project and that the CON program really aims to
18 achieve.

19 The first is to establish an orderly and
20 comprehensive health care delivery that will
21 guarantee the availability of quality health care
22 to the general public.

23 The second objective that should be
24 focused on is that it aims to improve the provision

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1 of essential health care services and increase the
2 accessibility of those services to the medically
3 underserved and indigent.

4 As you heard Dr. Shannon just now and
5 Drs. Keen and Turner speak this morning, this
6 modernization project at Provident Hospital meets
7 exactly those two objectives.

8 With respect to the SAR, Mike, thank you
9 for clarifying those couple of misapplications of
10 the rules.

11 I'm going to turn it to Jeff Mark, and he
12 can really discuss the bulk of the nonconformance
13 issues on project costs and the size and then the
14 key elements of utilization.

15 MR. MARK: Good afternoon. I'm Jeff Mark.
16 I'm the CON consultant to this project, and I
17 wanted to start addressing the specific findings
18 of the staff report. And I'll echo Ameer's thanking
19 the Board staff. We've had some lively exchanges
20 regarding the rules interpretation, but they've
21 done an excellent job.

22 I want to address the negative finding
23 which has to do with construction costs or cost
24 per square foot for construction costs.

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1 We are and this project is \$11, roughly
2 \$12 above the RSMeans figure that the Board used.
3 I want to point out that that's \$1.6 million in
4 total project cost or .7, 0.7 percent of the
5 entire project cost.

6 Rationale for this, we could argue many
7 things, but I would respectfully suggest that the
8 Board in its rules has modified a few things, and
9 RSMeans by definition is an average of the -- of
10 previous hospital's costs. So when you're looking
11 at an average of a hospital cost, it is comprised
12 of clinical areas as well as nonclinical areas.
13 That's what RSMeans is by definition.

14 So what the Board does is look at RSMeans,
15 which is an average of all costs, against just the
16 clinical costs. And the clinical costs tend to be
17 higher on average.

18 So to give an example, the cost of building
19 a radiology room or a surgery suite is
20 significantly higher than administrative offices.
21 So the RSMeans is an average of those two areas,
22 and the Board uses it to compare it just to the
23 surgery suite or radiology suite. I'll throw that
24 out as something for staff to ponder in the future.

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1 So yes, we are 0.7 percent over on the
2 budget -- over in our budget for construction costs.

3 The other factor negative I want to address
4 were the square footage guidelines or standards.
5 And of all the areas contained in this project,
6 all the clinical service areas we were -- the
7 project is slightly higher in two discrete areas,
8 and those are the med/surg bed units and the
9 ICU beds.

10 Again, this is a total square footage of
11 1,093 in excess of the Board standards or, again,
12 0.8 percent of the total square footage for the
13 project. So I would suggest it's not a huge
14 overage, but it is a deficiency according to your
15 rules.

16 A couple explanations for your
17 consideration is because of the nature of the
18 clinical programs at Provident, there is the
19 necessity of providing more isolation rooms in the
20 med/surg nursing unit, and that is one reason why
21 it takes more area to create an isolation bedroom
22 rather than a conventional. That's one reason we
23 have excess square footage.

24 Another rationale or another reason is

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1 that an ICU as planned contains the entirety of
2 Provident's respiratory therapy department.
3 Rather than having it in the basement and bringing
4 equipment upstairs, it was decided to house that
5 unit, use this service within the ICU, which is
6 the predominant user of that service.

7 With that said I believe that most of the
8 remaining findings on the part of staff have to do
9 with the utilization numbers at Provident, and to
10 address those I'm going to turn it over to Tanya
11 Seaton.

12 MS. SEATON: Good afternoon. I'm Tanya
13 Seaton, operating officer for Provident Hospital.

14 As Dr. Shannon indicated, a new modern
15 hospital would enable patients who reside in
16 Provident Ketchman area currently being treated at
17 Stroger to receive clinical care near their homes.
18 This is intended to improve access to care, improve
19 continuity of care, and expand availability of
20 services.

21 Our projections and analysis were based on
22 strong factors. We evaluated utilization numbers
23 prior to stopping ambulance runs and closing the
24 ICU. Additionally, we analyzed the patients seen

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1 at Stroger that resided in Provident Ketchman area,
2 which varies depending on the service, and adjusted
3 numbers based on the service and growth plans.

4 In keeping with the changes in the delivery
5 of clinical services, the project reduces inpatient
6 beds and increases outpatient clinical capacity.
7 We are proposing a reduction of med/surg beds from
8 79 to 42. Although the recent five-year report
9 reflects a need for 17 beds, we project we will
10 gradually increase our beds until we reach an
11 average capacity of 80 percent in 2022.

12 With the reopening of the ICU in May of 2019
13 our average daily census is improving. September
14 average daily census was 20.1. Additionally,
15 Provident has been operating a basic emergency
16 service for the last eight years. This project
17 incorporates the expansion of services to a
18 comprehensive emergency service. We project the
19 reestablishment of ambulance runs will further
20 increase med/surg, ICU, and ED volume. Our
21 current ED volume, as Dr. Shannon indicated,
22 without ambulance runs is close to 30,000 annual
23 visits. Prior to stopping ambulance runs some
24 years ago, it was over 40,000 annual visits.

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1 As Dr. Keen indicated earlier, we have an
2 aggressive elective surgery plan to reduce the
3 current backlog of cases and long delays for
4 procedures. Our plans don't start with the new
5 building; our plans start with the new fiscal year.

6 Dr. Keen has a 2 1/2 year plan that
7 includes hiring additional new providers and
8 expanding services. Providing adequate operating
9 rooms to improve access and prevent delays in
10 treatment is absolutely essential for this project.

11 We projected our diagnostic imaging numbers
12 based on the last three years of utilization and
13 visit volume projections. As Dr. Turner explained
14 earlier, for the last two years we have shown
15 patterns of growth in general radiology and
16 ultrasound services. This project will allow the
17 hospital to incorporate key services inside the
18 hospital versus using a CT trailer like we
19 currently use now to enhance the patient
20 experience and improve patient approval.

21 The projected outpatient visits will enable
22 Provident to serve its patients by expanding
23 existing services and providing ambulatory
24 services. Currently -- it is impossible to expand

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1 at this current time due to the infrastructure of
2 the building. We are asking for 70 exam rooms
3 that will allow us to provide new services such as
4 dental and oral surgery and expand services such
5 as ophthalmology and behavioral health. Due to
6 equipment and program requirements, these
7 specialties required specialized exam rooms that
8 cannot be used by other services.

9 The modernization project combined with
10 advanced technology solutions with the latest
11 diagnostic equipment, facility design, qualified
12 physicians, nurses, and allied health professionals
13 is essential to the community, to the county, and
14 to the health system. And we welcome your
15 questions.

16 CHAIRMAN SEWELL: I have a couple
17 questions. I want to go back to it -- do you,
18 Mike, have any comment on Mr. Mark's statements
19 about the Means standards and their focus on
20 general areas and what they're proposing are
21 clinical areas?

22 MR. CONSTANTINO: Yes. You know, by
23 statute we're supposed to separate those costs.

24 CHAIRMAN SEWELL: So you already did

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1 separate them?

2 MR. CONSTANTINO: Or they do it for us.
3 We accept what the applicant gives us. RSMeans --
4 that's true with RSMeans, yes.

5 CHAIRMAN SEWELL: And I also want to make
6 sure I have a correct understanding of your
7 response to some of these utilization issues.

8 It sounds like in moving to a comprehensive
9 emergency room you expect that to be a factor in
10 the utilization increasing for inpatient services
11 and even some of these services in this other
12 criterion related to general radiology,
13 ultrasound, et cetera.

14 MS. PATEL: Yes.

15 CHAIRMAN SEWELL: Now, I don't understand
16 the comment about the backlog of patients. Could
17 you say a little more about that? I'm not
18 objecting to it; I just don't understand.

19 DR. KEEN: Richard Keen.

20 Right now because there's -- Stroger
21 Hospital is basically an emergency hospital, about
22 40 percent of our patients originate from the
23 emergency room or the trauma unit, and a lot of
24 that is unpredictable. Our surgical schedule is

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1 basically full in order to try to be as efficient
2 as possible, but if there's a rush of emergency
3 patients, often elective cases get postponed or
4 canceled.

5 Our operating rooms work very late in the
6 day, which is not optimal from a safety standpoint.
7 We'll work as late as we can as long as we consider
8 it safe, but there is a backlog of elective
9 patients. Also, may be greater than 40 days before
10 they can get into our clinics, and then a wait
11 time after that to get scheduled for elective
12 surgery, and then there's a risk that that surgery
13 will be canceled because that day there's several
14 emergencies that need to happen because there's a
15 window where it's safe to proceed with that
16 emergency case. We kind of have to do it, and you
17 can only work so late where you have the trained
18 staff availability, all the parts that you need to
19 obtain good outcomes.

20 So we really have -- there's a tremendous
21 rush of demand for the surgical services that
22 we're feeling really squeezed trying to provide
23 for all the people that need them. There's an
24 urgency with emergency cases which basically push

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1 off some of other elective but still significant
2 need problems that are only best addressed by
3 surgery, and these patients get thrown off and
4 have difficulty managing those patients in our
5 system now. We really need -- it comes down to
6 having more OR capacity in order to be able to
7 handle those patients.

8 MEMBER MURRAY: Can I ask a follow-up?

9 DR. SHANNON: If I might to do that, as
10 both Dr. Keen and Ms. Seaton pointed out, we're
11 not going to wait for the new facility to build
12 capacity on that campus. If you look at the
13 growth and services that we've been providing at
14 the Provident campus over the last couple of years
15 and further growth, particularly in elective
16 surgical services, there's been the addition of
17 vascular, breast, plastics, general surgery, and
18 others. And we've had -- we established a few
19 years ago a concentration in ophthalmology
20 services because of the huge demand because of the
21 concentration of diabetics on the south side of
22 Chicago in particular, and so we've established a
23 center of excellence for ophthalmology there.

24 All of these things that we've been doing

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1 are to try to get to the point that, when the new
2 facility is opened, we've gone on a steady
3 escalator to get there rather than flip the light
4 switch and in 2023 we'll put it in there.

5 It has to do with not only the demand
6 that's out there particularly for those elective
7 surgical services but also the time that it takes
8 us to ramp up to get that specialized staff,
9 whether it's the surgeons, the anesthesia staff,
10 the operating room technologists, and so on.

11 CHAIRMAN SEWELL: Dr. Murray.

12 MEMBER MURRAY: I wanted to ask Dr. Keen,
13 how many ORs are at Provident, and are they fully
14 functional.

15 DR. KEEN: Right now -- we had a recent
16 issue with our HVAC that we had to postpone
17 surgery at Provident Hospital. Before that we
18 were running three to four rooms. We had demand
19 for much higher than that. We're basically
20 working on recruiting anesthesiologists, nurse
21 anesthetists, some surgeons -- we've already
22 started hiring more surgeons that we're bringing
23 into the system because we really can't -- because
24 of the demand in our clinics.

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1 I mean, my vascular clinic today has
2 135 patients, and I got a call -- during this
3 meeting I've been called for two emergencies
4 originally from the south side for help from my
5 other partners.

6 So the demand is definitely out there, and
7 we'd like to be able to address those problems
8 earlier before they become emergencies because the
9 outcomes are so much better. And that's part of
10 what's driving this is we see people come in -- a
11 lot of times these elective problems become
12 emergency problems, and the outcomes are not
13 as good.

14 So we've already started the process. As
15 Dr. Shannon brought up, we're already ramping up
16 in the existing Provident Hospital, and we are in
17 a situation do we use nine of those operating
18 rooms in the next two years. We plan to ramp up
19 that we'd be using those within the next two years
20 based on our plans and projections, based on the
21 current demand and backlog, patients we have right
22 now in our health system.

23 CHAIRMAN SEWELL: Dr. Martell.

24 MEMBER MARTELL: Can you comment a little

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1 bit on the number of respiratory isolation rooms
2 that you're anticipating a need for?

3 DR. SHANNON: Tanya, I believe the
4 application is for five rooms?

5 MR. MARK: I'm told there's six on the
6 med/surg floor.

7 MEMBER MARTELL: The application summary
8 says five.

9 MR. MARK: What I'm hearing, just to make
10 sure I'm correct, there are four isolation rooms
11 in med/surge and two in ICU; is that correct?

12 DR. KEEN: Five and one.

13 MR. MARK: Depends which side of the room
14 we talk to. Their total is six isolation rooms
15 for med/surgical and ICU.

16 MEMBER MARTELL: So are you planning to
17 use that Provident site as respiratory and
18 specialty care area?

19 DR. TURNER: No. In development plans we
20 thought it would be best to house respiratory
21 therapy near the ICU where the bulk of their
22 services were required.

23 DR. SHANNON: So I think your comment,
24 Dr. Martell, has to do with the fact that it's a

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1 relatively high number of negative pressure rooms
2 for the total number.

3 As I think you're aware, we've seen over
4 the course of the last several decades peaks and
5 valleys and resurgences of conditions that might
6 require a patient to be in a negative pressure
7 room. As it stands today, it's still the case that
8 our health system is way far ahead when diagnosing
9 and caring for individuals with tuberculosis that
10 are diagnosed in Cook County. We have on occasion
11 used all of the resources within the system most
12 appropriately.

13 So conceivably we could have patients who
14 are initially diagnosed with tuberculosis or
15 another transmissible infection like that at the
16 Stroger facility who might require prolonged care,
17 in which case a transfer -- if they're acute such
18 that they could be handled at the Provident campus,
19 it may be a more appropriate place to care for them.

20 So much of what you'll see in the
21 application is the fact that we operate our
22 two hospitals as a system with different
23 complexity and different support services
24 available at the Stroger campus than at the

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1 Provident campus, but we try to use them for the
2 highest and best use.

3 And I think that the conservative estimate
4 of putting in that number of negative pressure
5 rooms was to continue to have capacity for the
6 organization because we are a resource hospital
7 for the region and because we can't see 10 years
8 into the future as to what might be the next
9 emerging infectious disease or even what might be
10 happening with our tuberculosis numbers.

11 MEMBER MURRAY: I must say the application
12 which I tried to read has lots of copying of
13 accounting budget here, but I had trouble following
14 the thinking on the increased utilization. You
15 have a lot of data before 2011 and then like a
16 leap of faith. So I just wanted to point out
17 that's hard to follow.

18 My basic question is, has the Board for
19 the County Health System approved this
20 construction? Do they have faith in this
21 projection? Do they agree with this plan?

22 DR. SHANNON: Yes.

23 MEMBER MURRAY: They voted on it?

24 DR. SHANNON: They did not vote on it.

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1 What's been voted on is the capital improvement
2 plan at the county level, and the board has voted
3 on and approved two of our strategic plans, both
4 of which contemplate modernization of the
5 Provident campus.

6 MEMBER MURRAY: So they agree on a
7 replacement hospital?

8 DR. SHANNON: Yes.

9 MEMBER MURRAY: Did I miss that in the
10 minutes of the meetings?

11 DR. SHANNON: Well, we have not had a
12 specific vote at the board level on a new
13 Provident Hospital but rather it's been implicit.
14 We are operating a Provident Hospital. This is,
15 as the application says, a modernization effort,
16 and, in fact, as the Board is aware, it is a
17 downsizing of the current Provident Hospital.

18 MEMBER MURRAY: I just want to say that
19 concerns me because this is a government property
20 ruled by two boards, the County health system and,
21 of course, our elected County Commissioners. And
22 if neither one of them have voted yes, we want to
23 do a replacement hospital and these projection
24 utilization things sound very iffy, I'm concerned

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1 about this.

2 I would feel much better -- I mean, we have
3 lots of letters of support. I notice there's one
4 from the president of the Cook County Board, but I
5 would feel much more comfortable if, in fact, one
6 of these boards, but certainly the Cook County
7 Health Board had voted that yes, we want a
8 replacement hospital.

9 DR. SHANNON: I hear your concern,
10 Dr. Murray. Again, I want to be clear, the
11 Cook County Board itself through approving its
12 capital improvement plan and budget in
13 November 2018 approved this plan. That's included
14 in the CIP.

15 MEMBER MURRAY: It's included where in the
16 application?

17 DR. SHANNON: No, it's included -- I'm
18 sorry. Could you repeat that?

19 MEMBER MURRAY: You said it's included --
20 was it included in the application.

21 DR. SHANNON: I can't speak to that.

22 MS. PATEL: The CIP that Dr. Shannon is
23 referring to is included in the back of the
24 application. It's maybe a 100-page document.

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1 It's a budget. There are certain line items that
2 indicate what dollars have been allotted to the
3 modernization of Provident Hospital. I can check
4 the pages for you.

5 MEMBER MURRAY: I can find that but it
6 didn't say replacement hospital. I don't remember
7 it staying replacement hospital.

8 MS. PATEL: I don't think it specifically
9 says replacement hospital. However, it says
10 capital improvements for a particular hospital,
11 which would encompass a modernization project.
12 This is not a new facility that we're talking
13 about; it's just the modernization of the hospital.

14 MEMBER MURRAY: No, we're talking about --
15 I'm sorry; I might have it confused. I thought we
16 were talking about earlier a replacement building,
17 a separate building.

18 MS. PATEL: Well, it is a separate
19 building, yes, on a separate campus. But
20 according to your rules this is akin to a
21 modernization of the building. The hospital is
22 standing. It is currently there, correct. We are
23 moving its location and expanding services and
24 also decreasing certain inpatient services.

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1 MEMBER MURRAY: My real concern is to what
2 extent does the governing body for this entity
3 understand that and approve it? So to my memory
4 they have not voted on a replacement hospital.

5 I'm not talking about this particular
6 Facility Review Board's language, just in normal
7 parlance. So if I were to ask board members, "Did
8 you approve" -- I know it's been discussed at some
9 level. Did you approve it or not? To me that
10 makes a big difference.

11 So Jay knows what I'm talking about. So to
12 me that's an important thing that the Cook County
13 Board for the health facilities should agree to
14 vote -- they vote on stuff like this all the time --
15 to go forward with this.

16 Then I would be in a position of saying
17 here is a government entity that has a plan; did
18 they meet all the criteria. I'm leaving aside the
19 utilization thing; I think that may just be
20 confusion. But I'm having trouble doing that
21 today because they haven't voted on it.

22 DR. SHANNON: Just to clarify -- and
23 general counsel for the health system might have
24 to keep me honest on this, but the health system

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1 board, because the health system, per se, does not
2 own any of the buildings of the health system, the
3 County and the County government does. So the
4 bureau of asset management and the capital
5 planning portion of the County are the ones who
6 direct that activity.

7 As an example, on the Stroger campus we
8 recently started clinical operations last year in
9 our professional building which was largely a
10 replacement facility for other ambulatory space
11 that we used. There was never a vote of the
12 health system board on the construction of that
13 building. Rather, the Cook County Board in its
14 capital improvement plan approved funding for and
15 managed the construction of that facility that the
16 health system would operate within.

17 So the Cook County Board by voting on the
18 approval of the capital improvement project which
19 includes modernization of the Provident campus
20 tacitly does -- through vote approves a new
21 Provident building.

22 Similarly, that health systems board has
23 voted twice on strategic plans for the health
24 system that include modernization of facilities,

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1 and included in that is the anticipation and the
2 description of a modernized campus at Provident.

3 Jeff, do you want to introduce yourself?

4 CHAIRMAN SEWELL: Could you swear the
5 gentleman in?

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

8 (Three witnesses sworn.)

9 THE COURT REPORTER: Thank you.

10 MR. McCUTCHAN: My name is Jeff McCutchan.
11 I'm general counsel for Cook County Health.

12 The Cook County Health board of directors
13 in July voted to approve their current three-year
14 strategic plan. One of the specific provisions
15 in that strategic plan was for the new Provident
16 facility. So they specifically did approve a new
17 facility at Provident.

18 MEMBER MURRAY: So you're saying they did
19 approve it?

20 MR. McCUTCHAN: They did. Section 1.3 of
21 the strategic plan specifically referenced "Open
22 new health facilities at," and they listed several
23 clinic locations and the new Provident facility.

24 MEMBER MURRAY: Okay. Thank you.

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1 CHAIRMAN SEWELL: Now, the County Board
2 has approved the strategic plan for the system
3 or not?

4 DR. SHANNON: In fact, that's being taken
5 up this week Wednesday.

6 MEMBER MURRAY: So the County board will
7 vote on Wednesday?

8 DR. SHANNON: Yes. But the County Board
9 when it -- and, again, Jeff will keep me honest on
10 this -- they can only accept or reject the strategic
11 plan; they can't modify the strategic plan.

12 The health system board in July approved
13 the strategic plan for FY '20, '21, and '22, which
14 is the plan that Mr. McCutchan alluded to.

15 MEMBER MARTELL: I have a follow-up
16 question. The application talked about 60 percent
17 of the clients from the Ketchman area that
18 currently are at Stroger, and you talked about the
19 system. Will there be an impact on the Stroger
20 campus then? What's the current capacity of
21 Stroger and how would that impact that?

22 DR. SHANNON: So yes and I think it will
23 be a welcome impact on the Stroger campus. It's
24 very often at the Stroger campus that we find

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1 ourselves in the morning with 12 to 20 patients
2 waiting for a bed upstairs. It's frequently the
3 case that we're not able to accept a person who is
4 in our health plan but who is at an out-of-network
5 hospital and requires the complex care that can be
6 provided at the Stroger campus, and we're not able
7 to bring them in because we either don't have a
8 literal bed, or we don't have a bed of the type
9 that they need.

10 Because of the pressures that are on the
11 Stroger campus we think that this will be actually
12 an improvement, and we'll see an improvement not
13 only in throughput and in patient safety in the
14 emergency department at Stroger, but we should
15 also see significant impact on our left-without-
16 being-seen proportion, which right now is higher
17 than it should be. And it's something that I
18 feel, again, is not the best manifestation of safe
19 care to the community.

20 So we're looking forward to that. The
21 other piece about it is that for those individuals
22 who are currently at Stroger and are coming from
23 the Provident Ketchman area, it's really an undue
24 burden on them and on their families.

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1 But we anticipate particularly with some
2 of the changes that we're seeing in the ecosystem
3 around us, frankly, as the Westlakes, and the
4 MetroSouths, and other things of that nature
5 happen in Cook County, what we find is that
6 particularly for those individuals who are insured
7 by Medicaid or those individuals who are
8 uninsured, the private not-for-profit systems that
9 are around those facilities are not interested in
10 taking care of those populations, and we think
11 that there's going to continue to be increased
12 demand on the Stroger campus for that reason,
13 as well.

14 MEMBER MURRAY: Could you tell me what
15 page of the plan that is on?

16 MR. McCUTCHAN: Sure. Section 1.3 on
17 page 12 of the Impact 2023.

18 MEMBER MURRAY: Thank you.

19 CHAIRMAN SEWELL: Do Board members have
20 additional questions?

21 MEMBER SAVAGE: Are you taking ambulance
22 runs now at Provident?

23 DR. SHANNON: We are not.

24 MEMBER SAVAGE: And do you have any plans

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1 to sort of ramp up your volume at Provident to
2 account for these 42 beds?

3 MS. SEATON: Oh, yes. Absolutely. So we
4 are preparing now to have ambulance runs in the
5 first half of 2020, and so we anticipate once we
6 have those, the need for med/surge beds will ramp
7 up, and we will not have to transfer to Stroger as
8 frequently as we do now.

9 MEMBER MURRAY: I'm trying to read fast,
10 and I'm having trouble finding it.

11 CHAIRMAN SEWELL: Maybe I'll ask this
12 question while Dr. Murray is reading fast.

13 Do you have people that walk into your
14 existing emergency service that are nonemergent?
15 What do you do with them?

16 DR. SHANNON: You're speaking at the
17 current Provident facility?

18 CHAIRMAN SEWELL: Yes, at the current
19 Provident, not when you became a comprehensive.

20 DR. SHANNON: They're cared for the same
21 way we ordinarily would. At both the Provident
22 campus and at the Stroger campus, if a person has
23 a subemergency room need, if you will, they will
24 be taken care of and assessed for stability as

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1 required, and then at both campuses, if the better
2 place for care for them is at an ambulatory site
3 that we have open on the same campus -- and we do
4 this with children, for instance, at the Stroger
5 campus; we'll do it for certain clinical
6 conditions at the Provident campus -- a clinic is
7 in session upstairs, if you will, that would be
8 better suited to care for them. After they've been
9 assessed in the ED, they'll be transferred there.

10 CHAIRMAN SEWELL: After a patient like
11 this has been assessed, do you have arrangements
12 with ambulatory care providers in the area around
13 Provident to send them to?

14 DR. SHANNON: Yes. So we have -- first of
15 all, in a managed care environment our first check
16 is to see is this person already impaneled at a
17 medical home in the area. That might be one of
18 our community health centers; it might be a
19 Federally qualified health center or a primary
20 provider. If we identify a person with ongoing
21 needs who does not have a primary care provider,
22 we will typically refer them to one of the
23 community health centers in our system.

24 MEMBER MURRAY: I found a little phrase. I'm

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1 not confident that either the Commissioners or
2 the Board understands they voted for \$240 million-
3 plus new hospital, but that's what it says there,
4 so I'll leave it alone. I'm sure if they get
5 upset and don't want to fund it, that they won't
6 have any money, so I'll let it go.

7 CHAIRMAN SEWELL: Dr. Martell.

8 MEMBER MARTELL: I have a question as far
9 as an expanded ICU family waiting area. Has that
10 been seen anywhere else? Because that was one of
11 the areas they identified was contributing to the
12 larger space.

13 MR. CONSTANTINO: Yes.

14 MEMBER MARTELL: Anyone else looking at
15 that trend anyplace else?

16 MR. CONSTANTINO: Have we seen that in
17 other applications for modernizations of
18 hospitals? We haven't -- what's happened, with the
19 threshold being so high, we don't see a lot of the
20 modernizations of hospitals that we used to. So
21 since you've been on the Board, you haven't seen it,
22 but, yes, that has been -- the ones that have been
23 brought to the Board, that has been part of the
24 reason for the expansion of the size of the ICU.

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1 CHAIRMAN SEWELL: All right. Any other
2 questions?

3 (No response.)

4 CHAIRMAN SEWELL: Roll call.

5 MR. ROATE: Thank you.

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

8 Dr. Martell.

9 MEMBER MARTELL: Yes, based on staff
10 report and testimony provided.

11 MR. ROATE: Thank you.

12 Dr. Murray.

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

15 MR. ROATE: Thank you.

16 Ms. Savage.

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

19 MR. ROATE: Thank you.

20 Mr. Slater.

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

23 MR. ROATE: Thank you.

24 Chairman Sewell.

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1 CHAIRMAN SEWELL: Next on the agenda is
2 H-08, Project No. 19-038, Alden Courts of
3 Waterford in Aurora.

4 May I have a motion to approve this
5 project to reclassify 44 sheltered care beds to
6 40 long-term care beds.

7 MEMBER SLATER: Move to approve.

8 CHAIRMAN SEWELL: Is there a second?

9 MEMBER SAVAGE: Second.

10 CHAIRMAN SEWELL: Would you introduce
11 yourselves and be sworn in.

12 MR. KNIERY: I'm John Kniery, K-n-i-e-r-y,
13 CON consultant.

14 MS. SCHLOSSBERG-SCHULLO: Randi
15 Schlossberg-Schullo, president, Alden Management
16 Services.

17 MR. MOLITOR: Bob Molitor, M-o-l-i-t-o-r,
18 CEO of Alden Management Services.

19 MR. OURTH: Joe Ourth, O-u-r-t-h, CON legal
20 counsel.

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

23 (Three witnesses sworn.)

24 THE COURT REPORTER: Thank you.

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1 CHAIRMAN SEWELL: State agency report.

2 MR. CONSTANTINO: Thank you, Mr. Chairman.

3 The applicants are asking the Board to
4 approve the conversion of 44 sheltered care
5 nursing beds to 40 skilled nursing beds on the
6 campus of a CCRC community located in Aurora,
7 Illinois, at a cost of approximately \$835,000.
8 The anticipated completion date is March 31st, 2021.

9 No public hearing was requested, and no
10 opposition letters were received. Support letters
11 were submitted to the State Board.

12 As stated on page 2 of the report, there's
13 a calculated need for 115 long-term care beds in
14 the Kane County long-term care planning area.
15 There were no findings related to this project.

16 I will have to point out, though, on
17 page 5 of your report I reported the wrong project
18 cost, and I do have a correction to that.

19 CHAIRMAN SEWELL: What is the correct
20 project cost?

21 MR. CONSTANTINO: We have that. That is
22 \$835,000.

23 CHAIRMAN SEWELL: It's not 19.2 million.

24 MR. KNIERY: Please, no.

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1 CHAIRMAN SEWELL: I'm just messing with Mike.
2 Do you have a presentation?

3 MS. SCHLOSSBERG-SCHULLO: Members of the
4 board, I'm Randi Schlossberg-Schullo, president of
5 Alden Management Services. I have with me today
6 Bob Molitor, our CEO; Joe Ourth, our CON counsel;
7 and John Kniery, or CON consultant.

8 First, I would like to thank Mr. Constantino
9 and Mr. Roate for their work on the completely
10 positive State Board staff report. There has been
11 no opposition to this project but rather
12 considerable support documented.

13 Many of you are new to the Board since we
14 were last here before you. I am proud to introduce
15 Alden to you today. We are a family-owned
16 operation founded by my father, Floyd Schlossberg,
17 and we've been providing long-term care in
18 Illinois for approximately 48 years.

19 The Alden network operates facilities
20 around the Chicagoland all the way to southern
21 Wisconsin. Alden's nursing payor mix consists of
22 76 percent Medicaid residents, and we have one
23 supportive living facility that has approximately
24 80 percent public aid residents.

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1 In addition to our health care facilities,
2 Alden has developed and currently operates
3 13 affordable independent living communities,
4 nearly 1,000 units throughout the Chicagoland
5 area. These properties were developed with the
6 State's low income housing tax credit program. We
7 also have two skilled pediatric facilities and
8 four DD facilities.

9 Staff has given you a detailed description
10 of our Waterford campus and a project description
11 under the executive summary on page 2 of your
12 report. However, if you look on page 243 of the
13 application, there's a full rendering of our campus.

14 This Waterford project is currently vacant
15 located on our Waterford campus in Aurora. Alden
16 of Waterford is a 38-acre retirement community
17 which has been thoughtfully developed to take care
18 of residents needing all different types of care
19 and all types of financial needs. This includes
20 assisted living, sheltered care, memory care, and
21 skilled rehabilitation and health care.

22 In addition to the health care option on
23 this campus, we have an affordable independent
24 living building, as well as market rate entrance

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1 fee independent living villas. We are now working
2 on our final phase of the community, and we broke
3 ground for 18 additional villas. So we're very
4 excited to finish out that campus.

5 As noted, Alden Courts of Waterford is
6 requesting to convert the remaining two wings from
7 sheltered care to skilled care. Our current
8 skilled 20-bed unit remains full, and we ask for
9 your approval to allow our existing memory care
10 residents on our Waterford campus to remain in
11 their homes as their medical needs begin to
12 outweigh their programmatic needs.

13 In addition, we also have 41 individuals on
14 our waiting list needing skilled memory care.
15 Although combining memory care residents from
16 sheltered care buildings to general and geriatric
17 skilled beds is the easiest solution, to combine
18 memory care residents and general geriatric
19 populations does not have the best outcomes for
20 our residents.

21 I would now like John to briefly go over
22 the overview of the project.

23 MR. KNIERY: Thank you. Good afternoon,
24 members of the Board.

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1 We are here to ask you for your approval
2 to convert the remaining 44 existing sheltered
3 care beds into 40 skilled beds at the existing
4 facility. This project is a continuation of what
5 this Board approved on November 17th of 2015 when
6 we converted the first wing of 22 sheltered care
7 beds into 20 nursing beds.

8 This project further reduces the overall
9 bed complements from its original capacity of
10 66 beds down to 60 and completes the realignment
11 of the memory care facility into the nursing
12 category of care.

13 As stated, this conversion as well as the
14 initial conversion approved in Project 15-037 was
15 sought only after detailed analysis of the market
16 was done and based in Alden's comprehension of the
17 needs of its residents.

18 There is a need for this project. Even
19 though this is a conversion project, the State's
20 nursing bed need applies.

21 Alden Courts of Waterford lies within
22 Kane County. The Kane County planning area has a
23 calculated need for 115 additional nursing care
24 beds. Upon project completion there will still be

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1 an outstanding need for 75 additional nursing
2 care beds.

3 Our existing skilled and sheltered care
4 facilities, Alden Estates and Gardens, are devoted
5 to residents not needing dementia or memory care,
6 as is this facility, the third licensed facility
7 on the campus, Alden Courts of Waterford.

8 Alden Courts of Waterford is devoted
9 strictly to residents who benefit from specialized
10 memory care, sometimes referred to as dementia
11 care or Alzheimer's care. The situation before
12 you is one where the applicant has existing
13 sheltered care residents who are aging out and
14 soon in need of nursing services.

15 In the lower levels of care, when a
16 resident's medical needs outweigh their programmatic
17 needs, they must be discharged. One thing that
18 research and experience has taught us is it is
19 extremely difficult and harmful to move a person
20 with dementia to a new environment. By approving
21 our application today you will allow us to keep
22 our current memory care residents in our community
23 when their health needs change and they need
24 skilled memory care services.

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1 We thank you for your consideration, and
2 we'd be pleased to answer any questions you may have.

3 CHAIRMAN SEWELL: Are there questions?

4 (No response.)

5 CHAIRMAN SEWELL: Roll call.

6 MR. ROATE: Thank you, sir.

7 Motion made by Mr. Slater; seconded by
8 Ms. Savage.

9 Dr. Martell.

10 MEMBER MARTELL: Yes, in support, based on
11 staff report.

12 MR. ROATE: Thank you.

13 Dr. Murray.

14 MEMBER MURRAY: Yes, based on staff report.

15 MR. ROATE: Thank you.

16 Ms. Savage.

17 MEMBER SAVAGE: Yes, based on staff report.

18 MR. ROATE: Thank you.

19 Mr. Slater.

20 MEMBER SLATER: Based on staff report and
21 testimony, yes.

22 MR. ROATE: Thank you.

23 Chairman Sewell.

24 CHAIRMAN SEWELL: Yes, based on staff report.

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1 MR. ROATE: Thank you.

2 That's 5 votes in the affirmative.

3 MS. SCHLOSSBERG-SCHULLO: Thank you
4 very much.

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1 CHAIRMAN SEWELL: Next project is H-09,
2 Project No. 19-139, Midwest Endoscopy Center in
3 Naperville.

4 May I have a motion to approve this project
5 to expand an existing ambulatory surgery treatment
6 center.

7 MEMBER SAVAGE: So moved.

8 CHAIRMAN SEWELL: Is there a second?

9 MEMBER MURRAY: Second.

10 CHAIRMAN SEWELL: Would you identify
11 yourselves and be sworn in.

12 DR. BERGER: My name is Scott Berger, and
13 I'm with Billie Paige, our CON consultant, and
14 also Ira Rogal.

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

17 (Three witnesses sworn.)

18 THE COURT REPORTER: Thank you.

19 CHAIRMAN SEWELL: State agency report.

20 MR. CONSTANTINO: Thank you, Chairman Sewell.

21 The applicants are asking the Board to
22 approve the modernization of an existing ASTC with
23 two procedure rooms for a total of four procedure
24 rooms and nine recovery stations at a cost of

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1 approximately \$6.9 million. There are no findings
2 related to this project.

3 The expected completion date is June 30th,
4 2020, which is a change that what is in the report
5 the report states December 31st, 2019. The
6 applicants requested this change on
7 October 11th of 2019.

8 No public hearing was requested, and no
9 letters of support or opposition were received by
10 the State board.

11 Thank you, sir.

12 CHAIRMAN SEWELL: Do you have a
13 presentation?

14 DR. BERGER: Good afternoon. My name is
15 Dr. Scott Berger. I'm one of the founders of the
16 Midwest Endoscopy Center in Naperville, Illinois.
17 I've also been the medical director of the center
18 since it first opened in 2008. With me today are
19 our CON consultants Billie Paige and Ira Rogal
20 from Shea, Paige & Rogal, Incorporated.

21 I'd like to first thank the IDPH staff for
22 their comments and their time spent in dealing
23 with our application. I'd also like to thank the
24 Board for allowing us to present our project for

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1 your consideration.

2 We are requesting your approval for the
3 expansion of our facility. It will remain a
4 single specialty ASTC limited to gastroenterology.
5 Along with this expansion the project will also
6 include an expansion of the adjacent medical
7 practice.

8 The reason for this very needed expansion
9 of the ASTC is so that we can continue to provide
10 high quality cost effective care to our growing
11 patient population. Currently many of our
12 patients are facing delays upwards of three to
13 four months, if not longer, before their much
14 needed diagnostic and therapeutic endoscopic
15 procedures can be performed.

16 As gastroenterology is concerned with the
17 prevention and early detection of colon cancer,
18 stomach, and esophageal cancer, along with the
19 diagnoses and management of many other serious
20 conditions such as Crohn's disease and colitis, it
21 can easily be seen how performing timely
22 procedures can be both life changing and life
23 saving.

24 Originally the cost of this project was

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1 estimated to be less than the CON threshold in
2 November 2016. Based on the cost estimates at the
3 time, Midwest Endoscopy Center obtained a
4 determination that a CON was not required.

5 Since that time, however, the project has
6 suffered from a number of significant delays both
7 preconstruction and construction-related. The
8 delays were so multifaceted that construction did
9 not begin until early March of this year.

10 As a result of these significant delays,
11 the majority of which were unforeseen and very
12 costly, along with a marked increase in equipment
13 costs over the past three years, we contacted
14 staff, and it was determined that we would need to
15 secure a CON permit and request approval for this.

16 We are available for any questions you may
17 have. Thank you.

18 CHAIRMAN SEWELL: Are there any questions
19 or comments?

20 (No response.)

21 CHAIRMAN SEWELL: Roll call.

22 MR. ROATE: Thank you, sir.

23 Motion made by Ms. Savage; seconded by
24 Dr. Murray.

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1 Dr. Martell.

2 MEMBER MARTELL: Yes, based on staff
3 report and testimony.

4 MR. ROATE: Thank you.

5 Dr. Murray.

6 MEMBER MURRAY: Yes, based on staff report.

7 MR. ROATE: Thank you.

8 Ms. Savage.

9 MEMBER SAVAGE: Yes, based on staff report.

10 MR. ROATE: Thank you.

11 Mr. Slater.

12 MEMBER SLATER: Based on staff report, yes.

13 MR. ROATE: Thank you.

14 Chairman Sewell.

15 CHAIRMAN SEWELL: Yes, based on staff
16 report.

17 MR. ROATE: 5 votes in the affirmative.

18 CHAIRMAN SEWELL: Thank you.

19 DR. BERGER: Thank you very much.

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1 CHAIRMAN SEWELL: The next agenda item is
2 H-10, Project No. 19-041, Fresenius Medical Care
3 Melrose Park.

4 May I have a motion to approve this
5 project to discontinue and reestablish an
6 18-station ESRD facility.

7 MEMBER SLATER: Move to approve.

8 CHAIRMAN SEWELL: Is there a second?

9 MEMBER SAVAGE: Second.

10 CHAIRMAN SEWELL: State agency report.

11 MR. CONSTANTINO: Thank you, Mr. Chairman.

12 The applicants are asking the Board to
13 approve the relocation of an existing 18-station
14 ESRD facility in Melrose Park in a medical office
15 building on the Westlake Hospital campus and
16 establish an 18-station ESRD facility in Melrose
17 Park at a cost of approximately \$7.4 million.

18 The new site is approximately seven minutes
19 from the current site. The anticipated project
20 completion date is April 30th, 2021. All current
21 patients are expected to transfer to the new site
22 if this project is approved.

23 According to the applicants, the reason
24 for the relocation is the medical office building

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1 housing the clinic receives its utilities, repair,
2 maintenance, and security services from Westlake
3 Hospital. Since January 2019 these services have
4 declined to a point that Fresenius is uncertain
5 how long they will be able to maintain an
6 acceptable level of safety at the clinic. There
7 were no findings related to this project.

8 Thank you, sir.

9 CHAIRMAN SEWELL: Do you have a
10 presentation?

11 MS. WRIGHT: No, but I would like to thank
12 the Board staff and the Board members for
13 classifying this as an emergency application. And
14 since it meets all criteria, we'd be happy to
15 answer questions.

16 CHAIRMAN SEWELL: Are there questions?

17 (No response.)

18 CHAIRMAN SEWELL: Seeing none, roll call.

19 MR. ROATE: Motion made by Dr. Martell;
20 seconded by Ms. Savage.

21 Dr. Martell.

22 MEMBER MARTELL: Yes, based on staff report.

23 MR. ROATE: Thank you.

24 Dr. Murray.

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1 MEMBER MURRAY: Yes, based on staff report.

2 MR. ROATE: Thank you.

3 Ms. Savage.

4 MEMBER SAVAGE: Yes, based on staff report.

5 MR. ROATE: Thank you.

6 Mr. Slater.

7 MEMBER SLATER: Yes, based on staff report.

8 MR. ROATE: Thank you.

9 Chairman Sewell.

10 CHAIRMAN SEWELL: Yes, based on staff report.

11 MR. ROATE: Thank you.

12 That's 5 votes in the affirmative.

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1 CHAIRMAN SEWELL: Next is H-11, Project
2 No. 19-045, Fresenius Medical Care in Northfield.
3 May I have a motion to approve this
4 project to discontinue a 12-station ESRD facility.

5 MEMBER SAVAGE: So moved.

6 CHAIRMAN SEWELL: Is there a second?

7 MEMBER MURRAY: Second.

8 CHAIRMAN SEWELL: State agency report.

9 MR. CONSTANTINO: Thank you, Mr. Chair.

10 The applicants are asking the Board to
11 approve the discontinuation of a 12-station ESRD
12 facility in Northfield, Illinois. There's no cost
13 to the project, no support or opposition letters
14 were received, and there was no request for a
15 public hearing.

16 There is a current excess of 127 stations
17 in this ESRD planning area. All current patients
18 are expected to transfer to other Fresenius
19 facilities in the area. The reason for the
20 discontinuation is the low utilization of
21 approximately 10 percent. There were no findings
22 related to this report.

23 Thank you, Mr. Chairman.

24 CHAIRMAN SEWELL: Is there a presentation --

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1 oh, I'm sorry; I didn't look up.

2 MR. ALDERSON: Richard Alderson, vice
3 president, Fresenius Medical Care.

4 MR. HYLTON: Travis Hylton, manager of
5 clinical operations, Fresenius Medical Care.

6 CHAIRMAN SEWELL: Will you swear the
7 two gentlemen in.

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

10 (Two witnesses sworn.)

11 THE COURT REPORTER: Thank you.

12 CHAIRMAN SEWELL: Is there a presentation?

13 MS. WRIGHT: Again, this project meets all
14 criteria, but we'd be happy to answer any
15 questions anybody might have.

16 CHAIRMAN SEWELL: Do Board members have
17 questions?

18 (No response.)

19 CHAIRMAN SEWELL: Call the roll.

20 MR. ROATE: Thank you, sir.

21 Motion made by Ms. Savage; seconded by
22 Dr. Murray.

23 Dr. Martell.

24 MEMBER MARTELL: Yes, based on staff report.

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1 MR. ROATE: Thank you.
2 Dr. Murray.
3 MEMBER MURRAY: Yes, based on staff report.
4 MR. ROATE: Thank you.
5 Ms. Savage.
6 MEMBER SAVAGE: Yes, based on staff report.
7 MR. ROATE: Thank you.
8 Mr. Slater.
9 MEMBER SLATER: Based on staff report, yes.
10 MR. ROATE: Thank you.
11 Chairman Sewell.
12 CHAIRMAN SEWELL: Yes, based on staff
13 report.
14 MR. ROATE: Thank you.
15 That's 5 votes in the affirmative.

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1 CHAIRMAN SEWELL: The next agenda item is
2 H-12, Project No. 19-046, Fresenius Medical Care
3 Maple City in Monmouth.

4 May I have a motion to approve this project
5 to discontinue a 9-station ESRD facility.

6 MEMBER SAVAGE: So moved.

7 CHAIRMAN SEWELL: Is there a second?

8 MEMBER MURRAY: Second.

9 CHAIRMAN SEWELL: Staff report.

10 MR. CONSTANTINO: Thank you, Mr. Chairman.

11 The applicants are asking the Board approve
12 the discontinuation of a 9-station ESRD facility
13 in Monmouth, Illinois, not Galesburg. There's no
14 cost to the project, no support or opposition
15 letters were received, and there was no request
16 for a public hearing.

17 There is a current excess of 8 stations in
18 this ESRD planning area. The current patients are
19 expected to transfer to other Fresenius facilities
20 in Galesburg. The reason for the discontinuation
21 is the low utilization.

22 Thank you, Mr. Chairman.

23 MS. WRIGHT: Again, this meets all
24 criteria, and so we'd be happy to answer questions.

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1 MEMBER SLATER: What do you consider low
2 utilization?

3 MR. ALDERSON: Sir, at this time we have
4 six patients in this dialysis facility. So it's a
5 very small population, and two of those patients
6 are considering going to home therapy. So this
7 will give us only four patients there.

8 MEMBER SLATER: I notice in our staff
9 report -- I'm from McComb -- that utilization in
10 McComb is 37 percent compared to Monmouth at
11 35 percent. Is McComb on the cutting block, also?

12 MR. ALDERSON: No, sir, not at all.

13 MEMBER SLATER: Is it anticipated to be?

14 MR. ALDERSON: No, sir, we are not.

15 MEMBER SLATER: Why not?

16 MR. ALDERSON: Why not? Well, there's not
17 a need for both, but there's a need for one of
18 those facilities. So we're choosing to keep
19 McComb open. But I think we've moved three patients
20 to McComb, and one more is coming -- we've moved
21 two and one is going to McComb. There's a need
22 there. We're not looking at closing McComb.

23 MEMBER SLATER: Thank you.

24 CHAIRMAN SEWELL: Other questions?

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1 (No response.)

2 CHAIRMAN SEWELL: Roll call.

3 MR. ROATE: Motion made by Ms. Savage;
4 seconded by Dr. Murray.

5 Dr. Martell.

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

8 MR. ROATE: Thank you.

9 Dr. Murray.

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

12 MR. ROATE: Thank you.

13 Ms. Savage.

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

16 MR. ROATE: Thank you.

17 Mr. Slater.

18 MEMBER SLATER: Based on staff report, yes.

19 MR. ROATE: Thank you.

20 Chairman Sewell.

21 CHAIRMAN SEWELL: Yes, based on staff report.

22 MR. ROATE: Thank you. That's 5 votes in
23 the affirmative.

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1 CHAIRMAN SEWELL: Next is H-13, Project
2 No. 19-047, Fresenius Medical Care Waterloo.

3 May I have a motion to approve this project
4 to discontinue a 6-station ESRD facility.

5 MEMBER MURRAY: So moved.

6 CHAIRMAN SEWELL: Is there a second?

7 MEMBER SAVAGE: Second.

8 CHAIRMAN SEWELL: Could you identify
9 yourselves and then be sworn in.

10 MR. TIMMERMAN: Scott Timmerman, vice
11 president, Fresenius.

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

14 (One witness sworn.)

15 THE COURT REPORTER: Thank you.

16 CHAIRMAN SEWELL: State agency report.

17 MR. CONSTANTINO: Thank you, Mr. Chairman.

18 The applicants are asking the Board to
19 approve the discontinuation of a 6-station ESRD
20 facility, Waterloo, Illinois. There is no cost to
21 the project, no support or opposition letters were
22 received, and there was no request for a public
23 hearing.

24 There is a current excess of 16 stations

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1 in this ESRD planning area. The current patients
2 are expected to transfer to other Fresenius
3 facilities.

4 Thank you, Mr. Chairman.

5 CHAIRMAN SEWELL: Is there a presentation?

6 MS. WRIGHT: And for the last time today,
7 we'd be happy to answer any questions.

8 CHAIRMAN SEWELL: Do Board members have
9 questions or comments?

10 (No response.)

11 CHAIRMAN SEWELL: Call the roll.

12 MR. ROATE: Thank you, sir.

13 Motion made by Dr. Murray; seconded by
14 Ms. Savage.

15 Dr. Martell.

16 MEMBER MARTELL: Yes, based on staff report.

17 MR. ROATE: Thank you.

18 Dr. Murray.

19 MEMBER MURRAY: Yes, based on staff report.

20 MR. ROATE: Thank you.

21 Ms. Savage.

22 MEMBER SAVAGE: Yes, based on staff report.

23 MR. ROATE: Thank you.

24 Mr. Slater.

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1 MEMBER SLATER: Yes, based on staff report.

2 MR. ROATE: Thank you.

3 Chairman Sewell.

4 CHAIRMAN SEWELL: Yes, based on staff
5 report.

6 MR. ROATE: Thank you.

7 That's 5 votes in the affirmative.

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1 CHAIRMAN SEWELL: We move to applications
2 subsequent to intent to deny, and the next project
3 is I-01, Project No. 18-048, Sauganash Dialysis in
4 Chicago.

5 May I have a motion to approve this
6 project to establish a 12-station ESRD facility.

7 MEMBER SAVAGE: So moved.

8 CHAIRMAN SEWELL: Is there a second?

9 MEMBER MARTELL: Second.

10 CHAIRMAN SEWELL: All right. Could you
11 identify yourselves, and I think two of you are
12 new to the table.

13 MR. KAPLAN: Sure. Joseph Kaplan, DaVita
14 regional operations director.

15 DR. HO: I'm Tammy Ho. I'm a nephrologist
16 at NorthShore University Health Systems.

17 MS. COOPER: Anne Cooper, counsel for
18 DaVita.

19 MS. FRIEDMAN: I'm Kara Friedman, counsel
20 for DaVita.

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

23 (Four witnesses sworn.)

24 THE COURT REPORTER: Thank you.

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1 CHAIRMAN SEWELL: State agency report.

2 MR. CONSTANTINO: Thank you, Mr. Chairman.

3 The applicants are asking the Board to
4 approve a 12-station ESRD facility in approximately
5 7100 gross square feet of leased space in Chicago,
6 Illinois. The cost the project is approximately
7 \$4.7 million, and the expected completion date is
8 April 30th, 2021. Letters of support were
9 received. There was one letter of opposition.

10 This project received an intent to deny at
11 the March 2019 State board meeting.

12 There is a need for 80 ESRD stations in
13 this planning area.

14 Thank you, sir.

15 CHAIRMAN SEWELL: All right. Is there a
16 presentation?

17 MS. FRIEDMAN: Just briefly. And just to
18 note this Board staff report is clean at this
19 point; there's no negative finding on it. We
20 appreciate the staff's assistance with that, and
21 we've successfully met the 1110 need and the 1120
22 economic viability financial feasibility criteria.

23 I'd just like to thank Dr. Ho for coming
24 to the meeting today and wanted to give her a

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1 chance to just provide a few comments, and then we
2 can answer any questions you have.

3 DR. HO: So I just wanted to say thank you
4 for your time, and, basically, what I'd like to
5 share with you all is our philosophy of care for
6 these patients and also to talk a little bit about
7 access to care.

8 As a nephrologist, I've been practicing
9 for about 20 years now, and I work with a group of
10 nephrologists, we're 7, and about 6 of them,
11 90 percent of them have been in our group for over
12 15 years. And the reason is that we all have the
13 same philosophy, which is we prefer our care to
14 begin at the time when the patient is diagnosed,
15 engaging the patient in their own understanding of
16 their disease process, helping them make decisions,
17 and educating them about their options.

18 This is often not a one-time deal because
19 as you're uncovering and dealing with people, they
20 take time, and they need a lot of return visits to
21 talk about what their options are in terms of
22 choices regarding what doctor they choose, what
23 medication they choose, and what dialysis they
24 choose. And we prefer to follow them from the

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1 time that they're diagnosed to the culmination of
2 the need for dialysis to whatever happens next,
3 transplant or end-of-life conversations.

4 So part of my work with these patients has
5 dealt with trying to help them be engaged, and
6 part of that engagement is recognizing that they
7 are more than their medical illness, which is also
8 important to understand they need to be -- if they
9 can, if they want to be active members of their
10 employment, and with their families, and with
11 their children. We're such an important part of
12 their lives but a really unimportant part of their
13 lives in some ways.

14 So the access to dialysis is a critical part
15 because, if it's difficult to access hemodialysis
16 when hemodialysis is their choice, it becomes much
17 harder to engage them and to keep them actively
18 involved in their world and their world separate
19 from their medical diagnosis.

20 The other thing I'd like to just share is
21 the need for dialysis units in Albany Park has
22 been discussed. Our patient population has grown.
23 There are growing numbers of primary care
24 physicians and family practice physicians from

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1 NorthShore that are establishing practices in that
2 region, as well as our partnership within Swedish
3 Covenant will increase our program in the area,
4 and we would like to be able to follow our
5 patients to their dialysis so that we can continue
6 our relationships with them.

7 Thank you.

8 CHAIRMAN SEWELL: Can I have a roll call?

9 MR. ROATE: Motion made by Ms. Savage;
10 seconded by Dr. Martell.

11 Dr. Martell.

12 MEMBER MARTELL: Yes, based on staff
13 report and testimony.

14 MR. ROATE: Thank you.

15 Mr. Murray.

16 MEMBER MURRAY: Yes, based on staff report.

17 MR. ROATE: Thank you.

18 Ms. Savage.

19 MEMBER SAVAGE: Yes, based on staff report.

20 MR. ROATE: Thank you.

21 Mr. Slater.

22 MEMBER SLATER: Yes, based on staff report.

23 MR. ROATE: Thank you.

24 Chairman Sewell.

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1 CHAIRMAN SEWELL: Yes, based on staff
2 report.

3 MR. ROATE: Thank you.

4 That's 5 votes in the affirmative.

5 MS. FRIEDMAN: Thank you very much.

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1 CHAIRMAN SEWELL: There's no rules
2 development. There's nothing under unfinished
3 business.

4 Under other business we have the 2018
5 hospital profiles. What about them?

6 MR. CONSTANTINO: Yes, sir. We have
7 completed the 2018 hospital, ASTC, long-term care,
8 and ESRD profiles, and if you would approve them,
9 we will be posting them on the website tomorrow.

10 MS. AVERY: People are waiting?

11 MR. CONSTANTINO: Oh, yes.

12 CHAIRMAN SEWELL: All right. May I have a
13 motion to approve the hospital profiles? I don't
14 think the Board wants them.

15 MR. CONSTANTINO: I'd be happy to send
16 them to you. They're huge documents.

17 MS. AVERY: Are they not on the disks?

18 MR. CONSTANTINO: They're not on the flash
19 drives, no.

20 MS. AVERY: We used to put them on there.

21 CHAIRMAN SEWELL: Do you want to give an
22 overview of what the profiles are?

23 MR. CONSTANTINO: Yes. The profiles are a
24 summation of the data we collect from hospitals,

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1 ESRD, ASTCs, and long-term care facilities. It is
2 a utilization data. We collect Medicare and
3 Medicaid payor source information, patient numbers
4 by payor source, utilization of surgery rooms and
5 procedure rooms, as well as bed utilization.
6 Long-term care we do the same thing. ESRD we
7 collect the number of patients.

8 MEMBER SAVAGE: So moved.

9 MS. AVERY: I'm just going to clarify. If
10 you recall when we went through the orientation
11 and we said how they get to the numbers based on
12 need, we use those profiles for it.

13 CHAIRMAN SEWELL: Is there a second?

14 MEMBER SLATER: Second.

15 CHAIRMAN SEWELL: All in favor, aye.

16 (Ayes heard.)

17 CHAIRMAN SEWELL: Opposed.

18 (No response.)

19 CHAIRMAN SEWELL: The 2020 meeting dates,
20 nothing changed?

21 MS. AVERY: One date changed. There was
22 one date in November that was scheduled -- we were
23 scheduled to meet on Election Day. That's the
24 only day where we will have a Thursday meeting. I

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1 think it's November 7th. So that's the change.

2 CHAIRMAN SEWELL: That's in 2020. Yeah,
3 because it was election day.

4 Okay. Is there a motion to adjourn?

5 MEMBER SAVAGE: So moved.

6 CHAIRMAN SEWELL: Is there a second?

7 MEMBER SLATER: Second.

8 CHAIRMAN SEWELL: All in favor.

9 (Ayes heard.)

10 (Off the record at 2:46 p.m.)

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1 CERTIFICATE OF SHORTHAND REPORTER

2

3 I, Paula M. Quetsch, Certified Shorthand
4 Reporter No. 084-003733, CSR, RPR, and a Notary
5 Public in and for the County of Kane, State of
6 Illinois, the officer before whom the foregoing
7 proceedings were taken, do certify that the foregoing
8 transcript is a true and correct record of the
9 proceedings, that said proceedings were taken by
10 me stenographically and thereafter reduced to
11 typewriting under my supervision, and that I am
12 neither counsel for, related to, nor employed by
13 any of the parties to this case and have no
14 interest, financial or otherwise, in its outcome.

15

16 IN WITNESS WHEREOF, I have hereunto set my
17 hand and affixed my notarial seal this 3rd day of
18 November, 2019.

19

20 My commission expires: October 16, 2021

21

22



23 Notary Public in and for the
24 State of Illinois

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