ILLINOIS DEPARTMENT OF PUBLIC HEALTH
HEALTH FACILITIES AND SERVICES REVIEW BOARD
Tuesday, December 5, 2023
Bolingbrook, Illinois
9:00 a.m.

PRESENT:
DEBRA SAVAGE, Chairwoman
REX BUDDE
KENNETH BURNETT
GARY KAATZ
DAVID KATZ
DR. AUDREY LYNN TANKSLEY
MONICA LeGRAND
DAVID FOX
ALSO PRESENT:
JOHN P. KNIERY, Administrator
RYAN LEE, IDPH Ex-Officio
MICHAEL CONSTANTINO, IDPH Staff
GEORGE ROATE, IDPH Staff
DON JONES, IDPH Staff

MAGNA LEGAL SERVICES
BY: Michael Marciniak, CER
Notary Public

P R O C E E D I N G S

(Time noted: 9:00 a.m.)

CHAIRWOMAN SAVAGE: I now call the Open Meetings Act at section seven. We will have some members attending remotely via Webex. Meeting is not only recorded via the court reporter, but the entire Webex format will be recorded as required. Welcome everyone. And Happy Holidays. So George, would you please call the role.

MR. ROATE: Thank you, Madam Chair. Rex Budde.

MR. BUDDE: Present.

MR. ROATE: Thank you. Kenneth Burnett.

MR. BURNETT: Present.

MR. ROATE: David Fox.

MR. FOX: Present.

MR. ROATE: Monica Hendrickson.

MS. HENDRICKSON: Present.

MR. ROATE: David Katz.

(No verbal response.)

MR. ROATE: Mr. Katz? Moving on. Gary Kaatz.

MR. KAATZ: Present.

MR. ROATE: Thank you. And lastly, Deborah Savage.

CHAIRWOMAN SAVAGE: Present.

MR. ROATE: Thank you. That's six in attendance in-person and three in attendance via Webex.

CHAIRWOMAN SAVAGE: Okay. Now may I have a motion to allow board members, Mr. Katz, Mrs. Legrand, and Dr. Tanksley to attend the meeting via Webex for one of the reasons outlined in Section 7A of the Open Meetings Act.

MR. KAATZ: I Make the motion.

MS. HENDRICKSON: I second.

CHAIRWOMAN SAVAGE: Thank you. George, please call the role to allow the seating of these members.

MR. ROATE: Mr. Budde?

MR. BUDDE: Yes.

MR. ROATE: Thank you. Mr. Burnett.

MR. BURNETT: Yes.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes.

MR. ROATE: Thank you. Ms. Hendrickson.

MS. HENDRICKSON: Yes.

MR. ROATE: Thank you. Mr. Kaatz.

MR. KAATZ: Yes.

MR. ROATE: Thank you. Chairwoman Savage.

CHAIRWOMAN SAVAGE: Yes.

MR. ROATE: That's six votes of approval.

CHAIRWOMAN SAVAGE: Thank you. That motion was approved. Now we are going to change the format of our traditional agenda today to make accommodations for our rules with items number five and six. We all have made or have heard comments on our rules and we are making a concerted effort to prioritize the modernization of our rules. Also, I would like to remove items 13 and 14 from the agenda. We will hold the executive session at our next scheduled meeting. So now may I have a motion to approve the October 3rd, 2023 meeting agenda as amended.

MR. BUDDE: So moved.

MS. HENDRICKSON: Second.

CHAIRWOMAN SAVAGE: Thank you. George, if you could call the roll.

MR. ROATE: Thank you. Madam Chair. Mr. Budde.

MR. BUDDE: Yes.

MR. ROATE: Thank you. Mr. Burnett?

MR. BURNETT: Yes.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes.

MR. ROATE: Thank you. Ms. Hendrickson?

MS. HENDRICKSON: Yes.

MR. ROATE: Thank you. Mr. Katz?

MR. KATZ: Yes.

MR. ROATE: Thank you. Mr. Gary Kaatz.

CHAIRWOMAN SAVAGE: David Katz.

MR. ROATE: I'll move on. Monica Legrand.

MS. LEGRAND: Yes.

MR. ROATE: Thank. You. Dr. Tanksley.

DR. TANKSLEY: Yes.

MR. ROATE: Thank you. Chairwoman Savage.

CHAIRWOMAN SAVAGE: Yes.

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

CHAIRWOMAN SAVAGE: That motion is approved. May I now have a motion to approve July 27th, 2023 meeting transcript; May I have a motion?

MR. FOX: I'll move it.

MR. KATZ: Second.

CHAIRWOMAN SAVAGE: Thank you. Are there any changes or comments?

(No verbal response.)

CHAIRWOMAN SAVAGE: Okay, hearing none. George, if you could please call the role.

MR. ROATE: Thank you, Madam Chair. Mr. Budde? Yes. Thank you. Mr. Burnett? Yes. Thank you. Mr. Fox. Yes. Thank you. Ms. Hendrickson? Yes. Thank

you. Mr. Katz? Yes. Thank, thank you. Mr. Gary Katz. David Katz. Second. Mr. Katz. David Katz.

Thank you, Madam Chair. Mr. Budde?

MR. BUDDE: Yes.

MR. ROATE: Mr. Burnett?

MR. BURNETT: Yes.

MR. ROATE: Mr. Fox?

MR. FOX: Yes.

MR. ROATE: Thank you. Ms. Hendrickson?

MS. HENDRICKSON: Yes.

MR. ROATE: Thank you. Mr. Katz -- David Katz. Still no Mr. Katz. Gary Kaatz?

MR. KAATZ: Yes.

MR. ROATE: Thank you Ms. Legrand?

MS. LEGRAND: Yes. Yes.

MR. ROATE: Thank you. Dr. Tanksley?

DR. TANKSLEY: Yes.

MR. ROATE: Thank you. Chairwoman Savage.

CHAIRWOMAN SAVAGE: Yes.

MR. ROATE: Thank you. That eight votes in the affirmative.

CHAIRWOMAN SAVAGE: That motion is approved. So now we're gonad have a discussion of cardiac Cath

category of service. So I'll turn it over to you. Mr. Jones.

MR. JONES: Thank you Madam Chair. As many of you know the board has requested changes to its cardiac cath rules. Some sections of those rules were promulgated in 1987 and have not been updated since. So board staff has been working for several months to gather information to update these rules in terms of utilization standards, current equipment standards, current staffing standards.

Back at the October meeting it was suggested that we reach out to providers that we had been in discussions with during the fall and the summer to get their perspectives. And so we have confirmed the attendance of several providers across the state. The first entity that would like to make presentation is Northwestern Medicine.

CHAIRWOMAN SAVAGE: Okay. Say and spell your name for the court reporter, please.

MR. DAVIDSON: Sure. Thank you. Thanks for having us. I'm Charles Davidson.

MR. COHEN: My name is Dr. Ian Cohen.

MR. DAVIDSON: Thank you for having us here today, it is kind of amazing we talked about the last

time this was updated. I think back to early in my career. All. We really did in cardiac cath labs, diagnostic coronary -- orders, and we blew up balloons to try to treat blocked arteries; that was pretty much it. No catheter based -- was used for battling heart disease. Coronary stints, which everybody knows about were not even developed, medicated stints development took until about early 2000s. Bowel disease Started to be treated in the last 10 to 15 years. So I want to put some perspective that the cardiovascular labs are very different today than they were back then.

More complex procedures that were often thought to be in a surgical arena have now migrated to, to the cath labs. And this is not something that's a static, safe, slow process. Even over the past few years and continues to add from new technologies that have been developed. And patients increasingly want non nonsurgical procedures, right. They want a new non-invasive type of surgery.

And I -- I just brought a couple slides just to give you some perspective on, you've all heard of TAVR probably, which is Transcatheter aortic valve replacement replacing an aortic valve from a leg artery. And this is just looking at kind of the last

10 years we've been this doing for about 15 years at Northwestern Memorial Hospital. But you can see I don't want go too much detail, but you can see the TAVR back in 2013 when we were doing only 50 of them, we doing 150 open half open heart valve replacements to the aortic valve. Fast forward to about the last five years, as you can see that not only has there been a growth in the number of aortic valve replacements, but the TAVR has now become the predominant player that now makes up close to 70 percent of aortic valve replacements.

And that's not just true in Northwestern, but it's a nationwide statistic, I just got better access that we're used to getting at Northwestern. But this has transformed the treatment and that now occurs in the cardiac cath labs routinely as part of a heart team approach. So the surgeons are working in the cath labs routinely with the intervention cardiologists, which I am intervention cardiologist. But it's a much more team based approach in order to find what's the best for what patients. Some patients are still best treated in surgery, but you can see the vast majority are now migrated to that.

So the complexity of what we do now and

the need for surgical backup if there was a problem, one of these patients is -- is necessary to make sure we provide the best outcomes for these patients. Just one more slide too. So this is looking at one of our facilities, affiliated facilities at Central DuPage Hospital. They are more recent to this world of TAVR. We started with the early studies back over 15 years ago, at Northwestern downtown. But what you can see here is they gone from 88 percent open heart surgery, to replace aortic valves to now 75 percent catheter based catheter system. So this is only one example, Dr. Cohen is going to speak about coronary disease, but there's a bunch of valve programs that we're doing now. There's custom valves, heart -- heart failure therapies, all of those have migrated to this kind of hybrid area within the cardiac cath labs.

MR. COHEN: Thank you. Talk to you on, I think that the sea change that urgent terms of what Dr. Ben said was described is clearly demonstrated as well in terms of early intervention. And if you could extend it further into the electro physiology lab, we were doing electrode rhythmic studies lifting a, a significant improvement and lean towards non-surgical therapies. We were very, very limited in those in

terms of complications with interventional techniques. And this really started 5.8 percent -- 6 percent of patients needed to be rushed to the operating room.

But as skills improve technology improved, complication rates got lower and lower and started to see in probably be, I don't know 15, 16 years was a move to start to intervention services at hospitals that did not have surgical onsite data. But that was probably the biggest improvement since 15 years ago, probably a lot of years ago, probably 20 years to two three, like published over the course of the last 20 years, what's really committed to the chronic Cath level is a strategy of doing certain procedures in body caths that did not have surgical backup.

And then transferring patients who had much more complex diseases in the coronary arena to hospital that did have such backup to provide a level of safety that the patients required from complex procedures. The initial guidelines in terms of bone surgical backup were published in 2003, but then updated in 2014 and they just were really attempted in 2024 we saw a lot of the change that have been. And schematically the algorithm we have behind you on the

slide is really a decision making process to decide what type of procedures should be done and what type of facility by an operator with significant experience, the one commonality of all of this that complex procedures, whether they on onsite or you know, surgery site or certain off sites with more experienced cardiologists, well versed in techniques in early intervention.

And so I think to summarize what in the broader sense, I think the biggest change has been modern catheters that's primarily before as a separate silent to get patients to the surgery suites, to have more complex surgical procedures done. And I think the modern catheter is much more hybrid between surgeons and cardiologists to complex procedures, both on the valvular side and coronary side in cath labs. You don't know if it's cardiologists in the operating rooms, but having surgeons in the operating room right now is -- most of it is elect.

I think if we understand where we are at in terms of the benefit of the services offered right now, I think it's a perfect time to re-look at strategies and thoughts of how we allow cardiac cath labs either to come online and places that had never

had cardiac cath labs, you know, before, as well as to see how you extend the advanced cardiac cath lab offers afterwards that do a lot of complex work but do not have such back up to allow them to really move towards broader approach in terms of providing the cloud services that a local communities trust state.

MR. DAVIDSON: What we want to do is provide more access to patients. I think that's going to evolve as technologies have grown. I think out safety and, what we do better. What we want to do also provide is provide access patients to this type of care. I think we're a bit limited in some degree. I want to add to that, that has to have proper quality insurance to implement this program. There are some work, for example -- how many procedures need to be done on the side and how much done on the Cath lab based side option. To open and maintain program members administrators. They want to be able to demonstrate their outcomes.

I think if we're -- it's one thing to allow it to occur, we have to be sure that proper quality oversight is, is achieved and the proper volume is achieved to maintain that quality. 'Cause there's still been a hybrid between volume. And I and I, I

think that's where maybe some of the earlier rights from, from CA and Sam not really didn't address that. 'Cause It was a very different world, which doing fairly simple procedures back then, the technology was not -- in complex procedures. I'll be happy to answer questions on specific areas we can touch on that.

CHAIRWOMAN SAVAGE: Any questions from our board members?

MR. KAATZ: I have a question. Do you -- for TAVR's that are now performed in the cath lab, is a surgeon always in the cath lab and you foresee that practice to be continuing?

MR. DAVIDSON: That's a good question and it is actually CMS who is the surgeon has to be present as well as interventional cardiologists. That was one of the initial improvements paths we have for that. The answer to that is yes. There have been discussions of whether that will continue. But nothing has changed in this country as far as that guidance goes. There are other Cath lab interventionists that

MR. KAATZ: Approximately how many of those TAVR procedures migrate to a surgical solution? Unless -- other questions? If I may. Are there any established the desired volumes for Some of these elective

procedures such as TAVR?

MR. DAVIDSON: TAVR is recognized by American College cardiologist and the American Heart Association about guidance? I didn't bring it with us today, make this all the numbers. There's guidance regarding the surgical volume that has to occur in the hospital in order to start the TAVR program. And there's guidance on what -- and it's also part of the probate you have to send all of your data to the National Cardiologist registry which includes your outcomes, that's the benchmark that gets us to --

And so again, if we're thinking about this here, it really has to be dialed in, not just how do you develop one, but how do you ensure that the embodiment is of adequate quality in one -- And that's always something that's, you know, been concern of ours is making sure that we could do year after year. We're doing that. Maybe we have one year when one hospital, doesn't have that number, but what is it doing to --

MR. KAATZ: And that's apart of the cardiology database.

MR. DAVIDSON: Yeah, it's actually the cardiovascular data registry which is highly recognized by cardiologists. It's also supported by the surgical

thoracic society combined within. So when it was put together it was done very nice. The whole thing is to the collaboration, this whole heart team occurred around the time when cath labs -- and is now migrated to the coronary world as well. We talked about coronary we have a heart team meeting about transplant versus -- this heart team concept got it operating.

MR. COHEN: I'm sorry, just to add on then. I think the message worked from that heart team approach. Now I want to see how that approach applies very much to whether patient surgery, bypass surgery or someone gets multiple stints implanted, a discussion amongst surgeons and cardiologists that the part of the function. So traditionally we would send the patients to non -- surgical basis to see if that can be accomplished successfully. The problem is that in some hospitals who have surgical coverage, we have to transfer the patient from a hospital without surgical coverage, to achieve the procedure being done. Oftentimes the same operators are moving from hospital. So if we really want to make those kind of procedures more available to patients we need coverage that privileged areas sort of best ability to travel. We have to then have the same budget terms of guidelines,

software guidelines, digital oversight, quality matrix, we need to allow some of those hospitals the ability to then provide Cath lab procedures. Which then segues into surgical probably not part of discussion, but has continue of really provide applied care.

CHAIRWOMAN SAVAGE: Okay. Any other questions?

(No verbal response.)

CHAIRWOMAN SAVAGE: All Right. Hearing none. Thank you so much, doctors.

MR. DAVIDSON: Feel free to follow up with questions. Thank you.

MR. JONES: Our next group is Advocate Aurora Healthcare.

CHAIRWOMAN SAVAGE: Good morning. Please state and spell your name and then you can get started.

MR. JAFFE: Good morning. Dennis Jaffe, D-E-N-N-I-S, last name J-A-F-F-E.

MR. RAJU: Mahesh Raju, last name R-A-J-U first M-A-H-E-S-H. Good morning. We appreciate the opportunity to continue this discussion started by our, colleagues at Northwestern Medicine. I'm the cardiologist and I serve as the vice president of the cardiovascular service line at Aurora Health. It's nice to be here. We appreciate the opportunity to

participate in this morning's discussion regarding updating of the state rules regarding -- As the largest cardiovascular service line in the upper Midwest, spanning 27 hospitals from South Chicago to. Green Bay.

We are actively involved in the national conversation regarding how best serve our patients with a broad range of cardiovascular disorders. Technology, and innovation have been moving quickly as the threat to procedures that will continuing to expand from becoming less invasive and less risky. This is good for our patients, but has forced the cardiovascular community to reevaluate the traditional model and all of these procedures of high cost of beefing up settings.

The cardiac cath laboratory was traditionally housed in our -- hospital. We focused primarily on diagnoses, treat Coronary heart diseases at I previously mentioned. In today's department, capitalization, however, we're also now repairing and replacing heart valves. Repairing a non-intensive recipe again means planting the internal finish occlusion devices to prevent strokes closing atrial defect and much more all without making an incision.

This rapidly increase in volume procedures has created the need for additional cardiac catheterization laboratories. While being mindful of mitigating the potential rise of healthcare costs.

The expansion of the ambulatory surgery center capacity to observe the lower -- and to absorb the lower key lower risk cardiovascular procedures makes good sense. As it will not only make this care more affordable, but in improve patient satisfaction to enhance convenience personalized care. This will need to occur at the same time we maintain our current patient -- ion estimate. So how do we ensure that these facilities will adhere to the same standards as has been applied to any patient catheterization by and tertiary hospitals.

While the ASC still P-C-R registry will remain the standard bringing patient cath lab quality, as will be <unintelligible> accreditation process. We expect the new ASC registry to become an excellent tool for the peer review process for ASCs and we'll facilitate the trial with quality and confidence; this discussion will be available in early 2024. Participation is not mandatory. I want to -- CMS for other third party payers. So highlights participating

in those -- is as follows.

Each of these registries, both for inpatient care and ASCs are very game driven. Facilitate the assurance that patients are receiving the right care at the right time, that is the right sentence. It'll also allow each facility to benchmark their care and patient outcomes against similar facilities and against national standards. And these national standards in benchmarks will be updated quarterly. Each facility will be listed on the ASC patient websites currently the patients with care to watch will have the opportunity to use the find your heart phone tool for information on cardiovascular services.

And lastly, each facility will have access to ASC quality improvement for institution tool kits and the resources to help them measure the care and follow approval roles. And now for additional comments I'm going to turn it over to my colleague.

MR. JAFFE: Hi, so I'm the director of interventional cardiology, medical director of cardiology and advocate of Good Samaritan Hospital. I've been director for nine to 10 years in interventional structural endovascular procedures.

Point has to look at the state boards for definition of cardiac catheterization procedures. It is indeed very broad now taken.

So the current definition for cardiac catheter establishment does not take many recent procedures as was described earlier. It mainly has to paraphrase such procedures that this coronary Adrian brighter cath myocardial biopsy, pleural neutropenia fluid catheters somewhat with physiology procedures.

As you know, there are a lot more procedures that are done than labs today. So the current definition does not take any of those things in account. We would recommend that the safety of the CMS list of approved procedures as the definition moving forward. Would be beneficial for the definitions to be aligned between CMS and the state will ensure that the definition remains relevant and for payment files to remain aligned. This will allow the state's to add appropriate updates as they occur.

By producing data to the states that evaluate as each stage has developed. Besides society and geographic interventions are solid. As also mentioned, follow the CPT codes associated with procedures in determining what can be marked as season

one in addition of peer review requirement, states will provide a draft. We also updated the utilization standards to provide that service is adhered to.

Specifically the case staff draft states the target utilization should be 800 procedures annually. Currently is 200, within two years after initiation of the service. We understand that these standards are maintained only in additional -- to increase to 800 would be difficult for organizations specifically though that a clinical provider practice at more than one location, which is needed given their expertise providing patients more access to care. These standards are dependent on definition use.

Example, if they only include cardiac catheterizations in a cath room for self procedures that such as root implants provides rules should provide more information to this and indicate what our case procedures. This includes the more inclusive definition and the procedure volume requirement increased perhaps 400, but not closer to 800 annually by year two. One additional consideration from looking at buying requirements in the state track, is establish a new program. Current standard is no additional kits to be started unless each facility in

the planning area offering service operates at 400 procedures annually.

This suggestion is increased as to 1,000 This is all been significant for enrolling programs such as ambulatory site of care out of state. On the trend that is national is going to do more of patient collective Cath lab procedures. So I think it's, it's our role to try to make these rules be aligned with CMS to make this more fluid moving forward, and with that we will take questions.

MR. KAATZ: The question in my mind is, is it has changed months. I actually filed a first I state about a wife for <inaudible> about 400 years ago, and questions that I got asked back then were actually really, really interesting. But my questions based on a really recent event in my family's history. My Uncle up in Green Bay just had an ablation done and the catheter went where it wasn't supposed to and had to have this emergency surgery. Had his chest graft and, and fortunately he survived, but it was touch and go.

As we expand access and -- and I mean, how do we keep people safe? I realize since the time these things happening, hopefully very, very rare. But I mean that's -- that's -- that's my question. How

do we -- we do need to modernize, we do need to reflect the -- the gains in -- in this -- this discipline because remarkable. But how, you know, how do we give people safety?

MR. JAFFE: Well, I think we can never eliminate all risk of adverse from any sort of procedure, but I do think we have good data to -- to base decisions make <inaudible> treatment that case. As I mentioned earlier, the risk is going to go down another basic technique. So for example, there's a new technique <unintelligible>. If it's as advertised, it should be much safer for patients and we really anticipate moving a lot of those procedures to the outpatient site I mentioned.

So that's just a example. So I think we're never going to want to maybe fall procedures to maybe more an ambulatory settings. Patients are looking for that because We should be better staffed in some of these outpatient facilities. But I do think we can be certain based on the data and certain procedures was mentioned earlier there, there is certainly some really good data to suggest which patients are able to move to, to settings, which can both certain C one requirements.

MR. RAJU: That document thing I said sky guidelines, the state recommends I think lot of the ones that the society cardiologist Society recommended this case it was outpatient. Having a plan in place so they're not just saying that we have planned with something to be actually defined. That's what the American Heart Society recommends.

MR. KAATZ: Thank you.

CHAIRWOMAN SAVAGE: Any other question? You had talked about aneurysms. So what kind of aneurysms do you think can be done at A-S-C?

MR. JAFFE: Not very many. I think those are, that, that's an example of a -- of a complex procedure that is not very increasing frequency. Well, but that's the type of procedure that's recently taken without the <inaudible> capacity. So I really don't the data <unintelligible>. I'd love to hear about that. Other questions?

(No verbal response.)

CHAIRWOMAN SAVAGE: All right. Well thank you so much doctors and have a great day. And we'll move on to our next group, Don.

MR. JONES: Our Next group is Seven Illinois Healthcare. They are participating remotely, I

believe.

MR. AL-DALLOW: Good morning. Thank you very much for the opportunity. We appreciate the chance to participate and give feedback and I'll update to the board. My name is Raed Al-Dallow, I'm an interventional cardiologist at Prairie Cardiovascular here at Memorial Hospital of Carbondale. My colleague Mr. Mirza, Kathy Blythe(ph) and Garret Burton(ph) are on the Webex as well. We are located in region five here as a tertiary care provider for the southern part of the state.

We are a hub for a large STEMI program and a vascular care network. And we are also the trauma center south of Springfield, Illinois. We -- we are one of four facilities that provide catheterization laboratories. And over time, we became the first one the -- the only one with open heart surgery on site. Since the other programs have ceased to provide such services. Other presenters have already alluded to the evolution of cardiac catheterization laboratories.

Over the past couple of decades, the -- and for a variety of reasons, the level of complexity in the cardiac cath lab has increased

dramatically because of structural heart procedures, as well as the fact that advancement in medical therapy has led to focus the treatment of similar levels of disease into the medical therapy arena. And therefore, the complexity in the -- in the cardiac cath lab become more and more therapeutic place rather than a diagnostic place. And also it has become more complex therapies rather than the simpler ones.

This basically with regards to the definition of the cardiac catheterization category of service, this makes it a -- a rather perfect time to revisit the previous definition. We do believe that there is a need to update and clarify the definitions for the overall category of service. There also needs to be further definitions about the electrophysiology versus interventional procedures. There's also quite a bit of overlap between the cardiovascular procedures and the endovascular procedures that are being performed more and more commonly in the cardiac catheterization laboratories.

So we do believe that a new definition should reflect that evolution that has occurred in the cardiac cath labs over the past couple of decades. Also, for the same reason, and because of the level of

complexity, having a rigorous attempt to maintain quality and safety of those procedures is also very reasonable and timely. It -- it is certainly reasonable that a standard peer review process should be implemented. We do feel that the national the NCDR registry is the gold standard for -- for cardiac procedures. We do support that some form of a peer review and NCDR participation should be required.

It is to be noted however, that there is a certain cost that is non-trivial that comes with this participation. Not only the cost of subscription, if you would, but also there is FTE cost associated with data extraction. So a mindful selection of what level of involvement in the NCDR database and how extensive the data should be. Some data are needed to maintain quality and safety, and others are probably more geared towards research processes. And in rural areas, the FTE support for the full blown database may need to be looked at in terms of how do we maintain the principle of quality without adding too much cost to the program.

Also, regarding utilization standards there is indeed a link between quality and volumes. And therefore we -- we do have a concern that therapeutic procedural quality is directly indeed

related to procedural volume, which I assume also is your concern in the setting of physician standards. We agree that should be -- there should be a minimum requirement of about 400 procedures, their lab, and, and that there should be a, probably some sort of a facility minimum at about 800 to a thousand procedures.

These minimum utilization standards will establish some sort of guidance in terms of what would be appropriate volume to maintain quality in a lab per lab volume or per facility. And finally regarding the expansion and modernization of, of, of a catheterization laboratory. We certainly feel that for modernization and expansion of existing cardiac catheterization facility the approval should probably be required in association with a certain threshold of a capital expenditure.

This could be a new requirement. The idea is to maintain ability to modernize a cath lab or allow some sort of level of recruitment replacement and upgrades without necessarily requiring a CON. A lot of the associated imaging that comes with a catheterization laboratory, a lot of the supportive services and ultrasound access, which has been highlighted in the latest guidelines are actually

necessary in caths labs. But whether or not a CON is required to upgrade a caths lab to those level is, is something should be looked at.

Thank you for your time and my colleagues and I will be pleased to take any questions.

CHAIRWOMAN SAVAGE: Do we have any questions for these doctors?

(No verbal response.)

CHAIRWOMAN SAVAGE: Okay. Thank you so much, doctors. Don, our next group.

MR. JONES: Our next group is Rush University Medical Center.

CHAIRWOMAN SAVAGE: Good morning. You could state your name and spell your name for the court reporter. Sure. My name is Faisal Hasan, F-A-I-S-A-L; last name is H-A-S-A-N.

CHAIRWOMAN SAVAGE: Go ahead.

MR. HASAN: I'm representing Rush. It's a pleasure to be here. I'm an interventional cardiologist by bay and the chief of cardiology at Rush University. I am delighted to be here. It's a pleasure to be invited this forum. Couple of observations. It's -- it's really a pleasure to see approved first physicians from various facilities in

Illinois. Saying the same thing I think that we -- we compete with each other and yet when we can get together these forum, we can really bring together.

Catheterization as it's been very elegantly said before, has evolved since 1977 when the first percutaneous and now has evolved into structural peripheral and very complex arenas. But we are also seeing a migration of overall healthcare labs also, but also specific to the cardiac catheterization lab out of major hospitals and into ambulatory settings. And I think we are part of this transformational stage and how we play in this arena right now will dictate how we get set rules moving forward.

The goal should be to provide excellent healthcare with the utmost safety. I think that was a very good point that was brought up. The most people I know with in the most cost effective way. And so the question that last by my esteem colleague here is it's very well taken. And how do we get around that? Well, there's a couple of -- a couple ways. Phase number one is appropriate patient selection is going to be absolutely key in doing this procedures and an ambulatory setting.

The second is that, you know, if you have

a patient in a cath lab or a procedure area or in PT lab, admitted into the hospital, and you have to activate a surgical team, it is not an instantaneous activation. That activation itself can take up to two to three hours, even if the patient is at a facility where you have onsite surgical backup. And so that has to be taken into consideration. If you've got appropriate pathways where a patient can, can get transferred from a site without onsite surgical backup to a surgical site in a timely fashion, and those appropriate pathways are well delineated, then potentially these complications can be mitigated and -- and -- and handled appropriate appropriately.

The overall complication rate is -- is substantially lower than 1 percent in the range of 0.1 or 0.4 percent for these procedures, which would involve potentially having surgical backup; and the data is very clear about that. I would also like to address that we are discussing here two interrelated, but somewhat distinct points, and we should be very clear about that. The first point very eloquently brought, brought forward by colleagues from Northwestern is procedural expertise or procedures in the cath lab without on onsite surgical backup. That

that's one concept. And then as we evolve through that concept and we get into the next stage, well, the next stage is that we do these procedures in an ambulatory Setting; in an ASC setting.

Where clearly there is no surgical backup. And I think both of those are very feasible as long as we keep the focus on quality, providing appropriate care to our -- our communities, which Rush very much stands for, we are part of our community. And to do it in a cost effective way without compromising on patient safety. If we keep those high level principles in view, I think that we can create a mechanism to provide care to our patients in their respective abilities and do it in a -- in a very -- very -- very good way. Thank you. And I'm happy to take questions.

CHAIRWOMAN SAVAGE: Are you in the agreement about 400 procedures might be the amount of procedures to do in an ASTC?

MR. HASAN: I think that's a -- that's a great question. I think there's a lot of consideration there, I don't think it should be a very straightforward number for an ASC to just have 400 procedures cutoff. I think that you really have to get

into the details of how many operators are there what is the experience of the operators? Have they been in practice for several years, which makes a big difference.

Or is it a person fresh out of fellowship and coming into doing procedures? What is their cumulative experience over multiple years versus their most recent past one to two years of -- of experience? What we do know is that in a city like Chicago, operators are oftentimes operating in very low volumes. Particularly in the community. And we need to support these operators. It shouldn't be exclusionary. However, it should not be at the cost of compromising patient safety or patient care.

So I don't think that I can give you the number right now, but I think if we are thoughtful about it, and if all these themes that, that are here put our minds to it, we can clearly come up with a consensus statement. And as has been mentioned earlier, the side documents, so the society of coronary geography and, and intervention has come up with consistent statements. The first one for ambulatory care centers was in 2020, right after CMS gave me approval in January, 2020.

In May was a -- a document which was put forward, which is a -- a fantastic guideline as to what procedures can be done in ASC and still very much by the time contemporary now not -- not out of fact even though it's about three years old. The second document that was put forward by actually a combined group of side American College of Cardiology and the American Heart Association was updated this year. And that brings forward what sort of procedures can be done without surgical backup. And I think we're pushing the envelope on both of these trials.

However, there are certain principles that still apply and there are certain patient they just can be divided into patient characteristics and anatomic characteristics. And if we take these in combination, we can say that these are the types of patients which potentially should not be treated in an ambulatory setting and -- and more appropriately treated in -- in an in traditional hospital setting.

We have evolved now from mostly femoral access for GA catheterization procedures to regular radioactive, which is an artery in the wrist. And same day discharge for patients now across the country rather than close to a third of the patients. This is

still this stale data, but about a third of the patients get discharged same day after a procedure in the hospital. So very feasible that these -- these procedures can be done at the lower cost, potentially at the ambulatory care center with, with the utmost safety. But I think that what we should not compromise upon is a standard of quality and guidelines that -- that support what kind of procedures.

CHAIRWOMAN SAVAGE: Thank you. Okay. Other questions?

MS. HENDRICKSON: So you mentioned patient characteristics and setting aside quality and safety measures, is there a rationale as to ensure that the type of care that's seen at ambulatory also covers individuals that are underinsured or uninsured to take advantage of a low risk and potentially a quicker healing process, so to speak.

MR. HASAN: At lower cost? Absolutely. Yeah. You know, at Rush, we struggle with dispartment issues all the time. I think my colleagues at Northwestern have it somewhat easier as far as the despairing. But I -- I think that when we think about these questions, we really have to be mindful that we provide this care to, to all of our populations. I don't think that we

should start thinking about exclusionary characteristics as far as pyramids or insurance and things like that. I think in fact, if we do it right, we can potentially provide better care to a much larger population compared to what we are we are doing right now in, in a very -- way.

So I think that, I don't have the exact answer to what you're -- what you're asking, but if we do this right, this is a wonderful opportunity to set some of our -- some of the precedent, which I would agree with. I think we can be, make a better -- better thing for our communities.

MS. HENDRICKSON: So maybe a follow up would be, we've talked about volume, we've talked about quality measurements and even registering of services that is measurable. Is there value then for coordinating payer mix as the sites?

MR. HASAN: As a data point, absolutely. I think it would be -- it would be good to know what -- what kind of patients we are serving. And I think that the city of Chicago is unique because it is if you go by the -- the zip codes, it very much dictates socioeconomic status. But there are a lot of studies that actually have backed that up. The Capricorn

database actually has utilized that, and one of our researchers showed that just zip code dictates outcomes in certain patient populations.

I think that data will be of tremendous value as we evolve along this path and as we provide care to more patient reports set.

MR. FOX: Dr. Hasan, I think you, you mentioned that there are a number of programs in Chicago that are not operating in a minimum of 400 procedures. Can you say a little bit more about that? How many places are there operating in a much lower volume level, and why is that?

MR. HASAN: So I don't have the data for what percentage are, are below. I'm sure that that's attainable. The city of Chicago is very unique in -- in that, in a very small radius. There are, by last count, about maybe three cardiac cath labs. This is probably more unique than New York City and Los Angeles, which are the two largest cities in the country; and Chicago is number three. Nowhere else, including Boston, do we have such a concentration of cath labs in such small area. So I think just by the nature of the fact that you've got a tremendous amount of cath labs that don't necessarily talk to each other

all the time it's a very divided community.

Each healthcare system has patient population that wants to hang on to that. I think that is probably the reason why we have relatively low volume operators and relatively low volume cath labs in the city of Chicago. Whether that's a good thing or bad, I think we really don't have data to support that, although generally seeking, it is clear that higher volume proceduralists and higher volume cath labs generally better and their outcomes are, are better than, than with out.

MR. KAATZ: I -- I love the presentations today, and I like that the three -- three legged stool patient safety colleague brought up, measured outcomes, and cost. This committee, obviously our charter, this board is responsible for the costs in many ways. And it excites me, but I -- I'm, I'm struggling with what power structures, and I'm trying to think of what -- what exists in Illinois now. I think one of -- one other person talked about making this world class.

Can we do something advanced, or try to achieve. And in Illinois, as in a couple other states, we have a prenatal unit, right, which has level threes, level twos, level ones, level three standard

responsibility for education. We have a comparable issue with Murphy Centers leaving the hospital. And we're struggling with what -- what should the rules be around that. What should the credentials be and what is the quality measurement to be considered.

We also have trauma surgery, trauma surgeon, another network, trauma surgeons that requires getting into -- Do you think it's feasible, my first question, Dr. Hasan do you think it's feasible to, we could ever see a cardiac network like we see in those two areas?

MR. HASAN: It would be a dream come true. I think that we have on multiple levels demonstrated that when we have brought together and -- and sessions such as this and we put our differences aside, which are almost nonsensical, they are within healthcare, we are all in the same boat, we are all here to take care of patients. We all want best outcomes for our patients. Why would we not be able to come together? I think it's -- it's unfathomable that as physicians we can't come together and -- and create something which is really for our plan.

I experienced recently at the American College of Cardiology, Illinois chapter, they

specifically invited the chiefs from all the major centers, predominantly academic medical centers, but all major centers across Chicago and a few beyond Chicago. And it was one of the most wonderful sessions that feedback was tremendous because we also sat on the same stage and we were talking to each other and we quote unquote compete with each other, which again makes no sense whatsoever. But if we brought -- brought our collective brain power and our collective know-how, and our collective experience to the same table, we would be a force that to recognize.

And I don't think that other states have done it in fact. And that is where opportunity lies is to truly collaborate and, and be one unit as far as the dimensional gap community for, for Illinois for that matter. And it can be lead by top leaders in from some of the best centers in the world in Chicago. And and we can create something that is really special. And Europe has done that on multiple levels. They -- they don't compete with each other. They combine their sources. Sweden is a very big example, the Netherlands for example. And those are countries, bigger, big countries that have done that. We can certainly

MR. BURNETT: Do they have better outcomes than

we have.

MR. HASAN: They have better monitoring of, of outcomes for sure. And a lot of the data that we have in cardiology actually comes from some of the pivotal studies have taken place.

MR. BURNETT: Thank you.

CHAIRWOMAN SAVAGE: Other questions.

(No verbal response.)

CHAIRWOMAN SAVAGE: Hearing done. Thank you so much, doctor.

MR. JONES: Our last group is representatives from Corazon Incorporated; they are a cardiac consulting firm here in the United States.

CHAIRWOMAN SAVAGE: If you could introduce yourselves and spell your name for the court reporter.

MR. SWANSON: Sure. I'm Ross Swanson, R-O-S-S S-W-A-N-S-O-N, Chief Operating Officer for Corazon.

MS. WESLEY: And I'm Carol Wesley, C-A-R-O-L W-E-S-L-E-Y, Vice President with Corazon.

MR. SWANSON: And we're also very happy to be here today and really appreciate the presentations we heard before, for us really would not want to see anything that was said by the esteem Physicians that went for us. Our goal here today is really just to

talk to you about what we see as a national organization. And so we're not really advocating anything. We're, we're here just to basically tell you our experience and share the landscape will.

So we did put together a presentation, I know that there's copies in front of the board and I know that it was also produced online for other members to see. For those of you that may need a quick reintroduction, our report is on -- is one of the preeminent national consultancies for cardiovascular service line development. And we've actually assisted with CON regulations in over 20 states. So we're -- we're very comfortable talking about cardiovascular regulations at that level.

If you actually go to slide three, I think this speaks to a lot of what you've heard with the physicians earlier. There is this rapid timeline of adoption that's occurring, Carol and I are going to be focused today on cardiac cath in coronary intervention. I know EP procedures and other things were mentioned by the prior speakers, but their current regulations really call that out. We're seeing a lot of movement in that area as well, and I know that I've addressed this group before with testimony just at the last

meeting. But what I wanted to call out on that slide was that there's such rapid movement as we've seen, and you've heard the prior speakers talk about. Angioplasty with surgery offsite and the movement that has created and really created a, a wonderful barometer to look at as we're opening access to care for these patients. And now you all have been at the forefront for approving procedures to do coronary procedures in the ambulatory surgery treatment setting.

So with the safety profile and the technologies that exist with these procedures that the prior procedures -- that the prior speakers talked about, you're certainly going to see rapid movement with that; we just outlined some of that in this slide. I'd really like to stop just for a bit on slide four, which actually is a map with the United States that shows the current state of affairs with angioplasty without surgery on site. And if you went back only eight or nine years, I would call it more of a patchwork quilt.

You can see that we only have a few colors on that map now, and Illinois being one of those states that is fairly unregulated when it comes to

acute care facilities providing PCI without -- heart surgery. And this map continues to change, recently Maine was a state that was fairly restricted. The only state in the United States that's left that is truly completely prohibitory to our knowledge is Vermont, when it comes to allowing PCI without surgery onsite or not allowing I should say. And your neighbors in Iowa have a little bit of a sticky situation going on there.

Because they actually do have in their regulations, they don't allow it. But there's centers that have started that are actually suing the state. They're actually providing the service already, but they're suing to change those regulations. And -- and at any time, we know the format's a little long if you have a question for us please don't hesitate to stop us. The next slide, slide five here really talks about cardiac ASC regulations by state. And you can see that Illinois, this is a band of states with Kentucky, West Virginia, Virginia that has restrictions, but there's approvals that are allowed to take place.

And you can see that those states in green are fairly unregulated. There's some states in the southwest where there's really virtually no regulations when it comes to providing those services

in an off-site or a non-hospital or acute care setting. There's two states you're going to hear a lot about today, in our talk with just a really hot off the press in terms of recent regulatory change. My home state of Pennsylvania where our company's mails from, as well as Michigan have had some recent changes.

And I think we're going to continue to see these progress along for some of these other states in red. For instance, Pennsylvania passed a senate bill earlier this year. That as long as the procedure is on the CMS covered procedure list, it's allowed to be done in advance. The only evaluation that the ASCs go through is a facility departmental survey, if you will, an occupancy survey. And if they need architectural guidelines and requirements, the providers just allow -- they're permitted to actually perform cardiac caths and angioplasty in that facility.

Very controversial because it's actually more restrictive for hospital facilities than it is for the ASC, So that's causing a little bit of uproar In our local market. Michigan has passed legislation just this last year, they are a CON state to also allow movement of these procedures to the ASC setting. They have some pretty prohibitive guidelines

in terms of volumes as well as quality and accreditation mandates that we're going to talk about later. There was a wonderful question to that gentleman right there Mr. Kaatz about developing something similar to a trauma or the prenatal network.

Michigan just passed a law last month, that's a semi rule for heart attack patients that basically sets up that standard of care for STEMI PCI programs and it's going to follow the same quadrants that the trauma programs do, hospitals are going to be designated as their referral or a receiving center. Missouri has legislation -- works would be similar to that. So we really provided this for your records and to let you know that Illinois is not alone. You're not renegades, you're certainly not cowboys, like we say with our folks in the Texas markets.

So with that, I'm going to turn it over to Carol who is going to talk a little bit about some of the guidelines that I eluded to earlier.

MS. WESLEY: Yes. So if you move on to slide number six sky the society for cardiac intervention that was referenced several times by the other physicians. They have documented their cath line best practices. This focuses on their current consensus,

it's very patient focused. It's very evidence-based in terms of the approach to care. And as Dr. Hasan, he was bringing to us to mention, it's really about optimizing quality and outcomes more so than designating particular volume that needs to be done.

And that's done through the best practices through registries and through the usage of, you know, the vascular access sites. If you move on to slide number seven, this is really just the highlights of what that sky document from 2023 here the consensus document outlined. So it talks about those levels of service, level one and level two; level two being non-surgery on site that's more defined by level one and two by a volume differentiation. So level one, less than 200, level two greater than 200.

And we're talking PCIs here, not necessarily authorization. So I know we provided you with a definition list in terms of the differences between diagnostic catheterizations and then the interventional procedure of PCIs. And they talk about you know, staffing physician requirements, which we're going to get into a little bit more later on. And to inclusion criteria and quality monitoring as well.

MR. SWANSON: The one comment I want to make on

volume related to that slide is that the document does state that quality can certainly exist in programs that do less than 200. There's just additional scrutiny metrics in place at times. I think two good examples would be New York and New Jersey. They both have a volume threshold within their requirements. Programs are not prohibited or told that they're going to be shut down or go on probation if they fall below those guidelines.

They just have to provide additional quality parameters back to the state; they just undergo additional scrutiny.

MS. WESLEY: Pennsylvania has that same requirements.

MR. SWANSON: Yeah, and they use 200 angioplasty like Pennsylvania's threshold as well. Like I said, we're not advocating these numbers, we're just telling you what's in the reds and, and what we see. On the next slide, slide eight, I wanted to address this because when I was here with the Springfield Clinic pulses for their ASTC, and I was providing testimony on their behalf. There were a lot of questions that came up around appropriateness and safety of the procedures. And I want to stick with appropriateness for just a

brief second.

So one of the things that came up a bit when we were talking, was about appropriate patients and criteria in ensuring that there wasn't over utilization at particular labs that may have been deemed "inappropriate". And so I just wanted to bring this forward to the group, very briefly here. One of the things that Dr. Tanksley asked me a question about the ischemia trial, which we're going to talk about in next slide. And I went on a little bit of a diatribe about making sure that we're monitoring what you'll hear in the cardiology world as the appropriate use criteria.

I know you're hearing that in other clinical specialties as well. This is significant scrutiny in the cardiology community right now, that ACCNCR database that you heard about from all the prior presenters, added appropriate use criteria measures to make sure that the right patients were being selected at the right time. And we weren't inappropriately sending these folks and promoting over utilization. Has been something that has been now been reported in that registry and is under a lot of scrutiny, in states where you have to submit your data, your NCDR to the

state body itself for review; that's actually one of the first areas that comes under scrutiny.

In that ischemia trial that was brought up in that case and that trial took place in 2020. It was reported that coronary revascularization did not lower cardiovascular event rates among patients with stable ischemic heart disease. But, but there's a big but, it did improve the disease specific health status of patients if they had angina or chest pain, which of course, the predominance of these patients, we're not saying how they get to the facility, but as a presenting symptom, one of the key factors in terms of how those patients present.

So they can -- these -- the results of that trial can only be applied to stable patients without Angionox. And coronary revascularization should be considered if they have recurrent symptoms of <unintelligible> high optimal medical therapy. And Carol and I are not physicians who can talk to the folks and that spoke prior related to that. But I would tell you that there is a lot of scrutiny around that over utilization that you're concerned.

Now, we really wanted to get to these next few slides that look a bit -- for lack of a

better word. And it really is going to talk about what we've seen in your current regs and what we see in other regs that they <unintelligible>.

MS. WESLEY: So the next couple slides, we're going to specifically talk about what those professional societal recommendations SKY, ACC, so forth. What are the typical practices that -- that we see across the nation when we go to different facilities, and how do they compare with your current CON requirements today. So you'll see on slide number 10, we address duplication of services and then utilization in volumes.

So the -- the societal recommendations and, and what we see really throughout when it comes to duplication of services and, and utilization and volumes is really all of that state CON. And I know that's sort of circular talk because you are looking to update your CON. And like you said, a lot of programs are following societal recommendations in terms of the PCI volume number of -- of 200 less than or greater than, but caveating it with it, it has a the quality control component to it.

So when you have like Dr. Hasan was saying a facility within Chicago, that -- that you can,

you know, throw a penny and, and hit a cath lab, you may not see 200, but does that mean they don't have a quality program. So that -- that's the piece that we want to engrain with this particular piece here. The next slide, slide number 11. The society guidelines breakdown physician requirements and staffing requirements. So they talk about board certification for the physicians in interventional cardiology that are, are doing the procedure in the labs.

To ensure that those physicians are quality, physicians have been trained appropriately and so forth. They talk about the physicians performing a minimum number, a lot of physicians will go to several facilities to do procedures, not just be at one -- one facility. So they talk about minimum volumes that those physicians should -- should do over that time. And even address in those training guidelines that if they don't do that number of what can be done to ensure that they're -- they're doing quality.

And they talk about being trained in resuscitation and treatment of complications. So when those things do occur on that rare occasion, less than in 0.1 percent, that they know what to do, how to get the patients to appropriate treatment. And then as far

as staffing --

MR. SWANSON: I just want to read this out of the PA rules I had to pull it up on my phone. When it comes to the physician requirement, the Pennsylvania rules, which are fairly contemporary, talk about the director of the cardio catheterization service shall be board certified in cardiology or pediatric cardio cardiology as appropriate. The medical staff, it talks about the physicians in the lab shall be either board certified on or have obtained pre-board certification status in cardiovascular diseases in specialized training and invasive procedures.

Again, we only mention that because very generically now your current rule just talks about specialized training in cardiology. There's no mention of board eligibility requirement.

MS. WESLEY: And then staffing wise the societal recommendations talk about minimum staffing requirements. They're not telling cath labs how many they have in there, but there's be minimum of three staff. And they delineate by goals, not necessarily by whether it's RN, a technologist, a -- a rad tech but by roles. So including someone to administer the -- the sedation and manage the airway, which is typically done

through your RN. Monitoring a recorder, a circulator these types of roles to be within the cath lab.

And we do see that in typical staffing within cath labs are three and four staff members depending on, you know, the cath lab, where it's at, what resources do they have and that type of thing. And then they talk about appropriate training for that staff as well. Professional guidelines say three to five years of experience, but that's not to say that you can't have somebody new come in who has the appropriate training with a mentor or somebody until they get experience. And your CON requirements right now talk about the Rad Tech being highly skilled.

Talk about some of the nurse training, but really has some older, not contemporary players in there. Like a dark room, somebody who's going to -- develops the film the dark room. The next slide, slide number 12, we go into some of the imaging requirements, equipment and supplies, and then the rescue and support equipment. So these three, your regulations don't really address specifics on these. They address a minimum utilization standard per -- per room or per year. But they don't really address requirements in terms of -- of imaging being a high

quality imaging digital archive system.

Fixed imaging rather than mobile is -- is typically recommended, as -- as far as equipment and supplies, there are a lot of pieces of equipment now that provide that safety and that appropriate use piece. So FFR, which is fractional flow reserve, and then IVUS, which is intravascular ultrasound are two pieces of equipment that the cardiologists now use to make sure that -- that appropriate use criteria is being met. And that the patient is getting the procedure done as safely as possible.

So those are recommended as well as monitoring the equipment and the appropriate inventory supplies. And then as far as rescue equipment, it is recommended that there is a room pump there in the lab. If you are ASTC -- you would still have that room pump, but that patient, of course would get transferred to the hospital setting. As well as the type of general resuscitation equipment and cupboard stents so that if there is a catastrophic event that the physician would deploy the covered stent and would be able to get to the hospital <unintelligible>.

MR. SWANSON: So yes, they're very granular those

regulations are -- to get down to these level of detail with this equipment. And we've actually supported that as an organization. 'Cause as we've been seeing this move to the ambulatory environment, can't skip. We have to make sure that these treatments are available regardless if it's in an office setting that now converted to an ASTC and so forth. So we -- we've been supportive of the level of granularity when it comes to this type of equipment discussion being put into regulation.

And then finally, if you go to slide 13 here, you'll see transfer of transport agreements -- and case selection. And there is a requirement in your current -- I'm going to start from the right of the slide versus left, right? You currently have a requirement for transfer agreement, but one thing that is lacking that we typically see in state regulations is that it has to dictate an unconditional acceptance of transfer of that patient by the receiving organization. States like California, the receiving organization has a chance to submit an affidavit to the state saying that they're as a receiving center, they're going to accept all newcomers from that other organization.

From a facility standpoint, right now your requirement in the CON talks about just availability of these key services at a very generic level. We do see a lot of recommendations refer to the FGI guidelines that I alluded to when I talked about Pennsylvania's regulations. So those will talk about minimal square footage, requirements of the rooms, isolation of control areas, and things of that nature. And then finally very important, there's no current requirement listed for case selection for patient types that are going to be done within these specific settings. And we have on here SKY societal recommendations.

This is another one where I really have to refer to my notes because I want to make sure I get this right. I think Michigan did this very well, Michigan's language states verbatim that, "the facility will adhere to patient selection as outlined in the sky, ACCAHA expert consensus document 2014 update with PCI without surgical backup published in 2014", and I'm going to say this part -- "and it's update for further guideline changes". So they did themselves a real good surface there because now they don't have to update their guidelines every year. And they refer to the SKY

document, the Professional Society, and they don't have to re-review it every time a medical professional society comes out with a new recommendation.

So that -- that we think is key. There's some other elements on the slide that I may not have addressed that I think are kind of a self-explanatory, like no requirement for EMS transport protocols in your current guidelines, and those are certainly addressed in formal recommendations. If you move on to slide 14, for quality assurance and review. The current Illinois regulation just talks about having a detailed mechanism for adequate peer review. I believe almost every provider that spoke before us talked about participation in the PCC NCPR, so you can see those comparisons with national benchmarks.

And you know, we also see items where the quality program and elements of that are actually called out in a lot of the CONs that we review, in terms of internal and external peer review. Having regular audit drills, et cetera, to make sure that safety piece is done. The last piece we put on here our accreditation was mentioned by one of the prior speakers. There's a few states that actually mandate cardiovascular accreditation within their guidelines.

And listed those here both Pennsylvania and Michigan, as I mentioned earlier, Georgia requires that for new startup programs. New Jersey does it for programs that aren't meeting their threshold that I talked about earlier. So they fall below that 200 marker that lab has to undergo and outside external review of the organization. And then I'll end it with one of the pieces that I thought was particularly interesting was an exception request component of the current CON that is an exception for alleviating existing capacity. And in the current code, I have no issue or -- or don't take any issue or concern with being affiliated with existing programs. The referral transfer agreements we talked about earlier, cost effective of course is, is a key item.

The one area that had us -- the antenna went up was existing programming and having more than 750 procedures annual per lab. And I know several of the speakers spoke earlier, you know, in the past these procedures were very homogenous in terms of what was being provided. You have people up here talking about structural work procedures like TAV or nitro equipment and so forth. You can get into a real slippery slope and Virginia is experiencing this right now, and

they're actually looking how to back out of this with their state regs. When you actually look at procedure requirements per room, most of the contemporary state regulations that we see in New York did this with the modernization of their legs -- regs, looks at the number of procedures per program.

So it's per facility, what those are, where the demands are being held. When you think about the fact that these procedures in rooms are actually taking longer in some cases, and you've heard that in some of the prior testimony in the last meeting. That is of significant concern for us, 'cause it can get real dicey when they're looking at that at a non service level. And so, we'll -- we'll end it with, and certainly take questions; that, you know, for us it's when we monitor regs, it's really about the balance of patient provider preference, patient access, and quality and outcomes.

CHAIRWOMAN SAVAGE: Thank you. Do any of our members have questions for Mr. Swanson.

MR. BURNETT: I have kind of a question. I sort of entered this discussion today in part focusing on numbers, minimum volumes for example. And then also the very important issue of on on-site surgery versus

backup surgery. But you've identified a number of criteria in your national search, which are around quality, which were around board certification, which were around compliance with ongoing society standards. And I think it really is a valuable contribution what the CON -- Thank you.

CHAIRWOMAN SAVAGE: Other questions? Now, at this time, I would like to invite all of our presenters that presented on Cardiac Cath, if you have any final comments, if you'd like to come up and say anything.

MR. SWANSON: We have that one extra comment for Monica, we did not find in any CON anything related to payer Mix directly mentioned. So, I think it was a great question for sure --

MS. WESLEY: And, and not to say that you can't be the -- the first state to put something in there. But we don't see any -- of the, the regs or the societal guidelines or anything in regards to that.

CHAIRWOMAN SAVAGE: Thank you. Are there other presenters want to come up for any final comments?

(No verbal response.)

CHAIRWOMAN SAVAGE: All right. Well we thank you so very much for all of your input and we will start looking at this and I'm sure we'll get back with many

of you. So thank you again.

MR. SWANSON: Thank you very much.

CHAIRWOMAN SAVAGE: Okay. So now we're back to Don Jones. Oh, one second. We'll take a five minute break and then we'll be back with rules development on our birth centers and such.

(Recess.)

CHAIRWOMAN SAVAGE: For the birthing center update on the process and the rest on the agenda.

MR. JONES: Thank you Madam Chair. I just wanted to let the board members know that last Friday on December 1st the Illinois Secretary of State approved your publication for the update to the birth center rules that is now in the Illinois Register. Both part 1100 1110 changes that you approved at your October meeting are now referenced here. I wanted to let the board know that the public has 45 days to submit any written comments regarding this proposal.

So that would expire on January 15th, 2024. Also wanted to let the board know that with the publication in the register, the board and the staff are now bound by ex parte communication provisions

under the Administrative Procedure Act. So essentially that means that the board or the staff cannot discuss with the public the substance of this proposal. So for example, if someone in the audience approached you and said, "when is the public comment period over?" You could communicate that to them, but if they came to you and said, "I don't like this proposal and here's the reasons why", your discussion would have to be memorialized and put into the record.

And then you would have to notify both the governor's office and <unintelligible> that a ex parte communication occurred, which I would like to avoid if we could. Most likely at the January meeting, any public comments that we receive, I will bring to the board's attention because any comment that we do receive, we have to respond to it. And I'd be happy to answer any questions about that.

CHAIRWOMAN SAVAGE: That's pretty clear. Any members have any questions about that?

(No verbal response.)

CHAIRWOMAN SAVAGE: All right. Also, on B there was cardiac catheterization and ASTCs states.

MR. JONES: Yes. I was just want to let the

board members know that based on today's discussions with these providers, it is unlikely that we will have a draft of comprehensive rule changes ready by the January meeting. There's -- there's items that were presented today that I don't believe the board has considered. And so we would need to look further into that and revise our drafts and most likely that would be something would provide you at the March meeting at the earliest. But hopefully we would have a -- a comprehensive draft to review at that time. And the last item on that portion of the agenda, there is something called a regulatory agenda. Oh, I'm sorry. You have a question?

MR. KAATZ: I, I was going to say and, and I'm sorry for going out of order, but I thought the idea to bring in the, the leadership that you did today, the, the following cardiology and thoracic physicians was an excellent idea. And I think we should take as much time, we should take as much time with -- you come up with something that was said by one of the individuals that could be a real example. Not organized by cardiac services <unintelligible>. But I -- I think it was great idea. I thought the presenters were excellent. I learned a lot, I think everybody here did, and I hope

we -- we continue working with them as -- as we build final numbers.

MR. JONES: And the last item on the agenda regarding rules developments you have a handout, something called the January, 2024 regulatory agenda. This is a requirement by JCAR. What they like for each agency and board commission to do, is to publish an agenda in both January and July of each calendar year. And that is merely to notify the public of possible rulemaking that you might do in the first six months of 2024. So John and I and the rest of staff had put that together for you to review. And if you're comfortable with that, if you could approve it and then we would submit that to JCAR to be published in the Illinois Register in the upcoming publication.

CHAIRWOMAN SAVAGE: And do we also publish our opposition -- report?

MR. JONES: So for public comment?

CHAIRWOMAN SAVAGE: No. What we say any JCAR, like if we approve those regulatory, the regulatory agenda, but you said it would be published somewhere. Is that something that our opposition support goes with that or --

MR. JONES: No. That that's merely published in

the register. It's just a notification to the public and to the industry that you might engage in rule making in this particular area. But we're not bound to do that; it's just a -- a notification to the public that this is something we are considering.

CHAIRWOMAN SAVAGE: And they can provide comment.

MR. JONES: For an agenda, they cannot.

CHAIRWOMAN SAVAGE: No. Any other questions about anything Don has talked about?

(No verbal response.)

CHAIRWOMAN SAVAGE: Okay. Well thank you so much Mr. Jones. Okay. So now may I have a motion to approve the legislative agenda?

MR. BUDDE: So moved.

MS. HENDRICKSON: Second.

CHAIRWOMAN SAVAGE: Thank you. George, if you can call the role.

MR. ROATE: Thank you Madam Chair. Mr. Budde.

MR. BUDDE: Yes.

MR. ROATE: Thank you. Mr. Burnett.

MR. BURNETT: Yes.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes.

MR. ROATE: Thank you. Ms. Hendrickson.

MS. HENDRICKSON: Yes.
MR. ROATE: Thank you. Mr. Katz. I don't believe he's on our WebEx. Mr. Kaatz?
MR. KAATZ: Yes.
MR. ROATE: Thank you. Ms. Legrand.
(No audible response.)
MR. ROATE: Ms. Legrand.
MS. LEGRAND: Yes.
MR. ROATE: Okay. Thank you. Dr. Tanksley?
(No verbal response.)
MR. ROATE: Dr. Tanksley is not with us.
CHAIRWOMAN SAVAGE: Dr. Tanksley, can you hear us?
MR. ROATE: She's not on the WebEx, ma'am. Madam Chair?
CHAIRWOMAN SAVAGE: Yes.
MR. ROATE: Okay. Seven votes in the affirmative.
CHAIRWOMAN SAVAGE: That motion is approved.
MR. CONSTANTINO: I'd like to let the record show that members David Katz and Dr. Tanksley have left the meeting. We still have a quorum present in place. Thank you.
CHAIRWOMAN SAVAGE: Thank you. There is no

public participation or comment.

So now we're going to move on to number eight; items approved by the Chair. So, I have approved the following 20 items on your agenda; please let the record note these items as approved.

And now we are going to move on to permit renewal requests.

A-01, NANI Sycamore Dialysis Sycamore, Illinois. May I have a motion to approve the nine month permit renewal of project 21-019. It is the second permit renewal request for this project.

MR. KAATZ: So moved.

MR. BURNETT: Second.

CHAIRWOMAN SAVAGE: Okay. If you could please identify yourselves and then you'll be sworn in.

MR. MORAVO: Good morning. Juan Moravo Junior; That's J-U-A-N M-O-R-A-V-O Junior.

MR. BRENNAN: Good morning. Bill Brennan, B-I-L-L B-R-E-N-N-A-N; Mark Silverman, that's Mark with a "K" Silverman, S-I-L-V-E-R-M-A-N.

CHAIRWOMAN SAVAGE: Can you swear them in?

(Whereupon:

JOHN MORAVO

BILL BRENNAN

Were called upon to tell the truth, and did so as follows herein after being duly sworn.)

CHAIRWOMAN SAVAGE: George if you could please proceed with the state board Staff report.

MR. ROATE: Thank you Madam Chair. On December 14th, 2021, the state board approved permit number of 21019. This is the second permit renewal request for this project. They have the -- the permit holder is asking for a nine month permit renewal. Thank you Madam Chair.

CHAIRWOMAN SAVAGE: Thank you. Please proceed.

MR. MORAVO: Sure. Good morning members of the board. We're very happy to be with you here today for this permit renewal request for NANI Sycamore dialysis. With me today is the permit holder representative Bill Brennan, special projects manager for NANI and my partner Mark Silverman. This project was approved by the board in December of 2021, and there's been some updates since we filed our request for this renewal.

First, you may recall that this project was brought forth by name following the closure of a facility in the geographic service area and NANI physicians looking for a way to ensure access for their

patients. The permit holder identified a undeveloped piece of land in Sycamore, Illinois. For those of you who may not be familiar, that's near DeKalb, Northern Illinois University. And this was raw land that was already zoned for a business park. NANI answered into an OI with the developer of the business park to construct the shell for their facility and then ultimately the goal of policing that space over the long term.

Since our request was filed with this board, the project's gone from being 25 percent complete to 30 percent complete. And that's as a result of the completion of the construction of the shell being done. So I'm going to stop there and I'm going to allow Bill Brennan for NANI to share more Substantive update on the delays and status of the project moving forward.

MR. BRENNAN: Thank you Board for Hearing our, our delay construction is underway. We've contracts have been lead. There's been a lot of delays that occurred -- occurred outside of our -- our -- our control. We're moving forward, it's just taking longer than we anticipated. There Lot of things that have been going on. There's a lot of development to the

south of us. I think that's impacted some of our progress. But overall we're moving forward.

MR. SILVERMAN: Members of the board. The only thing I'll add is we wanted to appear before you to let you know the project just continues. We can address any questions that you have that we can as expected and required to vote.

MR. KAATZ: Can you finish it at nine months?

MR. SILVERMAN: Yes, we shall.

MR. KAATZ: That's 30 percent done, roughly?

MR. SILVERMAN: Yes.

MR. KAATZ: And that's nine months initially from what date?

MR. SILVERMAN: That's the nine months from the, sorry, it would be nine months from the project completion date, which was December 1st. So now I think it actually sets it to September.

MR. BRENNAN: And Members the wild card, whenever you go with a third party. And that -- that's solving delays here, but we acknowledge sometimes you end up on their timeframe. The one thing we'll acknowledge if something has happened, we will obviously be here before you update. We thought it would be better to give you a realistic date than to set it so far down

the road that it wouldn't be a problem. But you also wouldn't have your September 2nd.

MR. KAATZ: What's the date?

MR. BRENNAN: It's September 2nd.

MR. KAATZ: I just want to make sure it can be completed in nine months. So dont have to come back and renew all that. If you need 10 months --

MR. BRENNAN: That would be able to give us a little bit more time, but again, no, we're moving forward. We have had that discussion that this is the amount of time we believe it should take. If there is another bump, we may be back. But we also made the determination that it was better to bat up in spirit of the rules than to say that we have 18 months when we think it's going to take longer.

CHAIRWOMAN SAVAGE: Other questions by board members?

(No verbal response.)

CHAIRWOMAN SAVAGE: Hearing none, George if you could call the role.

MR. ROATE: Thank you. Madam Chair, please correct me if I have my motions wrong. Motion made by Mr. Kaatz. Seconded by Mr. Fox.

MR. FOX: Correct.

MR. ROATE: All Right. Thank you. Mr. Budde.
MR. BUDDE: Yes.
MR. ROATE: Thank you. Mr. Burnett.
MR. BURNETT: Yes.
MR. ROATE: Thank you. Mr. Fox.
MR. FOX: Yes.
MR. ROATE: Thank you. Dr. Hendrickson.
MS. HENDRICKSON: First of all, thank you for making me a doctor.
MR. ROATE: I'm sorry.
MS. HENDRICKSON: Based on the provided documentation, yes.
MR. ROATE: Thank you. Mr. Katz.

MR. KATZ: Based on the presentation, yes.
MR. ROATE: Thank you. Ms. Legrand.
(No verbal response.)
MR. ROATE: Okay. I think we've lost Ms. Legrand. I'll come back and revisit. Chairwoman Savage.
CHAIRWOMAN SAVAGE: Based on today's presentation of the state board staff report, yes.
MR. ROATE: Thank you. That's six votes in the affirmative. Does that carry?

CHAIRWOMAN SAVAGE: Motion is approved. Yes.

MR. ROATE: Thank you.

MR. MORAVO: Thank you so much.

CHAIRWOMAN SAVAGE: All right. So next up is going to be A-02 Fresenius Kidney Care Chicago HSA-6, Chicago, Illinois. May I have a motion to approve the five month permit rule of project 19-035, which is the second permit for you to request for this project.

MS. HENDRICKSON: So moved.

MR. BURNETT: Second.

CHAIRWOMAN SAVAGE: Thank you. If you could please introduce yourself, spell your name for the court reporter and he can swear you in.

MS. WRIGHT: My name is Gloria Wright, G-L-O-R-I-A W-R-I-G-H-T; The specialist for Fresenius Kidney Care.

Whereupon:

GLORIA WRIGHT

Was called upon to tell the truth, and did so as follows herein after being duly sworn.)

CHAIRWOMAN SAVAGE: If you could share the state board staff report.

MR. ROATE: In October of 2019. The state board approved permit number 19035, the permit authorized the

relocation of an existing 24 station ESRD facility in Chicago, Illinois. State Board staff notes this -- this permit is obligated and the current project completion date is December 31st, 2023. Project cost is approximately $7.4M and the permit holders are asking for a five month permit renewal until May 31st, 2024. Thank you Madam Chair.

CHAIRWOMAN SAVAGE: Thank you. You can proceed.

MS. WRIGHT: This is the central relocation of Jackson Park facility --

MR. ROATE: Could you speak closer to the mic? Thank you.

MS. WRIGHT: It's the Jackson Park facility and we relocated the new addition near the Chicago Skyway. The original renewal request came to a decision for six rooms as well as Sunday that prepared to add home therapy east to the service area. That required, you know, re planning, looking at the size of the site, a parking addition that was quite expensive. Since that time and construction of university related from the shell, each building permit time took about five months for approval.

Shell construction and interior work was also delayed. The ground storage tanks that the

property had required had lengthy inspections before they could forward. And then after the construction was finished the city of Chicago was also probably understaffed like everybody else. That took extensive time to have them come out and do their inspections.

The facility did -- on October 23rd, and it's in operation now. So if there are more questions.

CHAIRWOMAN SAVAGE: So you did get the Chicago approval to move forward.

MS. WRIGHT: Oh yes. We're just -- we're just waiting for the CMS inspection and the receipt of CMS letter, which could come before December 31st. But in order to remain in compliance, we want to wait for the inspection receipt.

CHAIRWOMAN SAVAGE: Which you are expecting anytime now?

MS. WRIGHT: Yeah, it should be -- I don't think months out, but just to be safe so we dont have to come back and ask for an extension.

CHAIRWOMAN SAVAGE: Other questions from members?

(No verbal response.)

CHAIRWOMAN SAVAGE: Okay. Hearing none, George if you could call the roll.

MR. ROATE: Thank you Madam Chair. Motion made

by Ms. Hendrickson. Seconded by Mr. Burnett. Mr. Budde.

MR. BUDDE: Yes. Based on the staff report I vote yes.

MR. ROATE: Thank you. Mr. Burnett.

MR. BURNETT: Yes. Based on the staff report.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes.

MR. ROATE: Thank you. Ms. Hendrickson.

MS. HENDRICKSON: Based on the information, yes.

MR. ROATE: Thank you. Mr. Kaatz?

MR. KAATZ: Yes, based on the staff report.

MR. ROATE: Thank you. Chairwoman Savage.

CHAIRWOMAN SAVAGE: Yes. Based on the staff report and testimony today.

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

CHAIRWOMAN SAVAGE: Thank you. That motion is approved.

MS. WRIGHT: Thank you.

CHAIRWOMAN SAVAGE: All right. So now we are going to move on to the Exemption Requests. We have one item and its The University of Chicago at Glendale Heights, Illinois. The University recently acquired

Advent Hospitals. May I have a motion to approve the discontinuation of OB services at Advent Health Glen Oaks Hospital.

MR. BURNETT: So moved.

MR. FOX: Second.

CHAIRWOMAN SAVAGE: Thank you. If you all could introduce yourselves, spell your name for the court reporter and you'll be sworn in.

MR. RAGIVOJEVS: Good morning. My name is Vladimir Ragivojevs, V-L-A-D-I-M-I-R R-A-G-I-V-O-J-E-V-S.

MS. AYANYAN: Hi, good morning. I'm Deborah Ayanyan, A-Y-A-N-Y-A-N. I am the Chief of nursing.

MR. AXEL: Chad Axel, A-X-E-L; Axel and Associates.

THE REPORTER: Please raise your right hand.

Whereupon:

VLADIMIR RAGIVOJEVS

DEBORAH AYANYAN

CHAD AXEL

Were called upon to tell the truth, and did so as follows herein after being duly sworn.)

CHAIRWOMAN SAVAGE: Thank you. Mike, if you could give us our state board staff report.

MR. CONSTANTINO: Thank you. Madam Chair, University of Chicago Medicine, Advent Health Glen Oaks is 140 bed safety net Hospital located in Glendale Heights, Illinois. They propose to discontinue the 15 bed obstetric unit at the hospital. There is no cost to the discontinuation and the expected completion date is upon state board approval. The applicant's are before the state board because the application proposes a discontinuation of a category of service. This application for exemption was forwarded to the state board chairwoman for approval. The chairwoman recommended this exemption be submitted to the state board for approval. Thank you Madam Chair.

CHAIRWOMAN SAVAGE: Thank you Mike. If you'd like to proceed.

MR. RAGIVOJEVS: Thank you Madam Chairperson. Again, my name is Vladimir Ragivojevs and I'm the President and CEO of Chicago Advent Glen Oaks. Thank you for the opportunity to appear for you this morning and our <unintelligible>. We are here to answer any questions you may have about the decision made in July to suspend obstetric services, and subsequently filing of discontinuation of certification section allocation for you today.

As noted in your staff report, we found to be in compliance with all of our reviewed material. Glen Oaks is located in the city of Glendale Heights, one of the smallest hospitals within the Chicago suburbs and Archdiocese program. Is experienced steadily declining admissions during 2021 and 2022, we arrived less than five <unintelligible> of week an Advent census of just under 2.2 patients.

We do not believe our proposed discontinuation will have a material impact on access. Northwestern Central DuPage Hospital and Alexian Brothers medical centers are both located within the HSS RPP designated geographic service area. And together are approved to operate 64 open beds, experience combined rate of 6 percent. Our Average daily census of 2.2 patients is barely noticed.

We put policies in place to smooth transition process during the past five months, since suspension we haven't experienced any difficulties nor to the best of our knowledge have a patient historically looked to us for any of their <unintelligible>. With that introduction, we can now answer any questions you would have. And again, thank you for the opportunity for appearing before you today.

Mr. Axel, do you have any additional comments?

MR. AXEL: My only additional comment is to confirm that this application and all reviewed criteria reviewed by staff.

CHAIRWOMAN SAVAGE: I'd like to let the record reflect that Ms. Legrand is back online; board member. I do have a question. So when the University of Chicago took over at Advent Health Hospitals or merged, even though it wasn't noted that you were going to work <unintelligible> at this hospital. So why was that not discussed at the time by the Archdiocese?

MR. RAGIVOJEVS: Yeah, we didn't have the intention to close the services at that time when there was that merger. But when time continued, we ran into some difficult situations with staff. We had all the -- all the opportunity to, to work on staffing, just weren't able to find the ability to plug those holes. We have a number of staff that were burned out and staff that left the organization.

Even with agency staffing, we weren't able to provide the appropriate staff to arrange a situation where we weren't able to provide safe and adequate care. And so with all those things be considered, in conjunction to position with discussion

with our physicians and staff, we made that decision to suspend services.

CHAIRWOMAN SAVAGE: Other questions by board members. Yes, Mr. Katz, please.

MR. KATZ: What prenatal network are you in right now, Glendale?

MS. AYANYAN: Hi, good morning. The UCM worked very closely with Peggy Collins.

MR. KATZ: Who is your level three provider?

MS. AYANYAN: <Unintelligible> so UCM.

MR. KATZ: What's UCM?

MS. AYANYAN: University of Chicago Medicine.

MR. KATZ: And are you going to drop gynecologic surgery also?

MR. AXEL: No, we will continue to provide gynecologic services for inpatient operations.

MR. KATZ: That's going to be quite a drive for your primary service area, right? That's used going to Glendale Heights if they have to go to Alexian or Central DuPage.

MR. AXEL: It is a six mile drive to Alexian Brothers and about eight mile route to Central DuPage.

MR. KATZ: Do you have any OBs on your staff?

MR. AXEL: We do have OBs on staff, but they

won't be providing any services, they'll just be providing technological services.

CHAIRWOMAN SAVAGE: Other questions? You know, this is always IDPH's purview that you do have some training of your ER staff?

MR. AXEL: Yes.

MS. AYANYAN: We did extensive training and actually we had the OB nurses for eight weeks staff down in our ED area on both the day shift, night shift to support that. So we did didactic and return demonstration, simulation and the required education including hemorrhage and pre amp and also any of the equipment was relocated to make sure that the staff were aware we utilized the equipment. We also made sure that all the medications required were relocated. So that they're right there for the ED staff. And the great opportunity is that the prenatal network will help us continue on an annual basis to keep the staff training on an annual basis. And that is a great relief to us that the nurses that are in the ED and the providers.

CHAIRWOMAN SAVAGE: And did you have any deliveries since you've closed in the ER?

MS. AYANYAN: We have not had any deliveries. So

we did create a transfer algorithm. So immediately if anyone comes to our triage area, we have a varied process, step by step review or assessing the patient, seeing where their stability is, and then get them to the appropriate facility after we see the patient.

CHAIRWOMAN SAVAGE: Any other questions by board members? Oh, Mr. Katz.

MR. KATZ: Any letters of opposition?

MR. RAGIVOJEVS: We have not received any letters about opposition. I personally made phone calls throughout the community, EMS, fire, police, surrounding mayors, member of the villages. We -- we actually, we also posted within our Daily Herald, I've not received any phone calls from anyone. I spoke with other obstetricians and our board members and did not receive any letters of opposition.

MR. KATZ: Your board is totally onboard.

MR. RAGIVOJEVS: Totally supportive, Yes.

CHAIRWOMAN SAVAGE: Like said it's said because it was a beautiful unit. You go ahead.

MR. BURNETT: Yeah, I -- I would just add that operating a quality OB unit with an average census of 2.2 is a challenge. And certainly would be a challenge to track and maintain staff at those five levels. And

of course, it's -- it's extremely cost ineffective to provide <unintelligible> census 2.2.

MR. RAGIVOJEVS: It is. We recognize that and as we, as we were looking at the situation of not having enough staff, we recognize that it's difficult to, difficult to maintain competencies. And our staff presented that to us and we did ask staff if they would cover different shifts, those type of things as we did our best staff the unit, but we couldn't get there by a collective decision with our physicians and staff.

CHAIRWOMAN SAVAGE: Obstetric aside how is hospitals going otherwise in terms of nursing?

MS. AYANYAN: Always a challenge. Especially healthcare post Covid, so it -- it's something that we just, we continue to strive. Retention, recruitment, all those, you know, impact all of our areas. But we are doing okay. And we are looking to decrease in all of our areas. And it's significantly reduced in our, ICU in our med surg departments. We don't have any agency and that's a big accomplishment for us for sure.

CHAIRWOMAN SAVAGE: Any other questions?

(No verbal response.)

CHAIRWOMAN SAVAGE: George, if you could call the roll.

MR. ROATE: Thank you Madam Chair. Motion made by Mr. Fox, seconded by Mr. Burnett. Mr. Budde. Yes. Based on the staff report and the conversation today I vote yes.

MR. ROATE: Thank you. Mr. Burnett.

MR. BURNETT: Yes.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes. Based on staff report and testimony today.

MR. ROATE: Thank you Ms. Hendrickson.

MS. HENDRICKSON: Based on the testimony today, yes.

MR. ROATE: Thank you. Mr. Katz.

MR. KATZ: Based on the staff report and the presentation, I think the presenters are on top of this one. I will vote yes. However, my thinking behind it is that number one, you convert to Chicago medicine, I would expect Glendale Heights to add services not delete, but I do -- I -- I understand your position. And the second issue that I have as a board member, the first issue, and I'm not speaking for anyone else is every now and then we get a presentation for a birthing center. And we're starting to see hospitals close

their units. Doesn't make sense. My point is rhetorical I vote yes.

MR. ROATE: Thank you. Ms. Legrand.

MS. LEGRAND: Can you hear me, George?

MR. ROATE: Yes. Yes ma'am.

MS. LEGRAND: I vote yes also.

MR. ROATE: Thank you. Chairwoman Savage.

CHAIRWOMAN SAVAGE: Yes, I vote yes based on today's presentation and state board staff report, but I wish it could stay open.

MR. ROATE: Thank you. That's seven votes of the affirmative.

CHAIRWOMAN SAVAGE: All Right. That motion is approved. Thank you.

MR. AXEL: Thank you.

CHAIRWOMAN SAVAGE: Okay. So next up we're going to have declaratory rulings and other business. So we have the E-01, birthing center declaratory ruling. May, I now have a motion to approve the department's request to grandfather the existing and already approved birth centers permits from the alternative Healthcare Delivery Act to the newly established birth centers licensing Act.

MS. HENDRICKSON: I take that motion.

MR. FOX: Second.

CHAIRWOMAN SAVAGE: Thank you. So John could walk us through this request.

MR. KNIERY: Thank you Madam Chairwoman and members of the board. Since we met last, the department of Public Health licensing passed the Birthing Center's Licensing Act and put their rules together. Our role is previous <unintelligible> for Birthing centers were under the alternative healthcare birthing Act. As existing facilities have to renew their licenses or as approve two of them, so as we approved, have to become complete c licensure. They now have to fall under the Birthing Center License Act, not Alternative Healthcare Delivery. Please know, that we have four existing facilities and have two that are under construction.

So I asked Karen Singer of the Department of Public Health to submit this declaratory ruling change in licensure of assisting facilities is one of the items the declaratory ruling process was defined for. In essence, as you stated, Madam Chairwoman, this request is asking you grandfather these facilities; all new facilities will have to follow a similar process, which we have filed our rules

to start that process.

CHAIRWOMAN SAVAGE: Thank you John. Don, if you could please give us the state board standard report on this.

MR. JONES: Thank you Madam Chair. As John mentioned, the Department of Public Health has submitted a formal request for a declaratory ruling. The reason that was done was that one of the models under the Alternative Healthcare Delivery Act was first in the model. And in 2021, that model moved and was recognized as a licensed healthcare facility under the newly adopted statute of the Birth Center License Act.

And then in September of 2023, the department promulgated new rules for the regulation licensing of birth centers known as the birth center licensing code. And when those rules were promulgated and established, the department reached out to John to determine if the six existing facilities that you approved sealed in permits for -- under the Alternative Healthcare Delivery Act, had to come back before the board for new CONs because they were going to be either -- either their existing license would be renewed under the Birth Center Licensing Act or the two facilities that you see on page three of your report.

They're not open yet, when they do open they will receive a license under the Birth Center Licensing Act and not under the Alternative Health Delivery Act. And, and the reason this all was started was that under the Health Facilities Planning Act, it states that if the facility is established and receives a license, that is viewed as an establishment of a new facility. So the department questioned the board, questioned us, and wanted to make sure that if they started issuing licenses under the new statute, the board would not view that as establishing a new facility with a new license. Thank you, Madam Chair.

CHAIRWOMAN SAVAGE: Thank you, Don. Karen Ms. <Unintelligible> do you have any comments?

MS. KAREN: No. Nothing to add. He gave a great explanation.

CHAIRWOMAN SAVAGE: Any questions from any board members on this matter?

(No verbal response.)

CHAIRWOMAN SAVAGE: Okay. Hearing none, George, if you could please call the role.

MR. ROATE: Thank you, Madam Chair. Motion made by Ms. Hendrickson, seconded by Mr. Fox. Mr. Budde?

MR. BUDDE: Yeah. Based on the staff report, I

vote yes.

MR. ROATE: Thank you. Mr. Burnett.

MR. BURNETT: Yes.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: Yes. Based on staff report and staff Comment.

MR. ROATE: Thank you Ms. Hendrickson.

MS. HENDRICKSON: Yes, based on the Staff's report.

MR. ROATE: Thank you. Mr. Kaatz. Based on Staff report I would say yes.

MR. ROATE: Thank you, Ms. Legrand.

(No audible response.)

MR. ROATE: Ms. Legrand, I'll come back. Chairwoman Savage.

CHAIRWOMAN SAVAGE: Yes, please. Based on Staff report and testimony today.

MR. ROATE: Thank you. Circling back. Ms. Legrand?

MS. LEGRAND: I vote yes.

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

CHAIRWOMAN SAVAGE: Okay. This declaratory ruling is approved. Okay, so now we are going to move

on to Applications Subsequent to initial review. That will be H-01, OSF Saint Joseph Medical Center, in Bloomington, Illinois. May I have a motion to approve 23-037 for the expansion of med surg and ICU within the hospital.

MR. ROATE: So moved.

MS. HENDRICKSON: Second.

CHAIRWOMAN SAVAGE: Thank you. As you all get seated, if you could please introduce yourselves, spell your names for the court reporter and he will swear you in.

MR. WEBER: Ralph Weber. W-E-B-E-R.

MS. FULTON: Lynn Fulton, F-U-L-T-O-N. President OSF Saint Joseph Medical Center.

MS. CALLUTA: Sarah Calluta. S-A-R-A-H C-A-L-L-U-T-A; Chief Medical Officer for Saint Joseph.

MR. HOHUMIA: M-A-R-K-H-O-H-U-M-I-A. COS for Saint Joseph.

THE REPORTER: Please raise your right hands.

(Whereupon:

RALPH WEBER

LYNN FULTON

SARAH CALLUTA

MARK HOHUMIA

Were called upon to tell the truth, and did so as follows herein after being duly sworn.)

THE REPORTER: You may proceed.

CHAIRWOMAN SAVAGE: Thank you. Mike, if you could share our state board staff report.

MR. CONSTANTINO: Thank you. Madam Chair. OSF healthcare system is proposing to have 10 medical surgical beds and 15 intensive care beds at OSF Saint Joseph Medical Center in Bloomington, Illinois at a cost of approximately $17.8M.

The expected completion date is December 31st, 2026. There was no public hearing requested, we did receive letters of support but no opposition letters were received. We did have findings regarding this project. Thank you Madam Chair.

CHAIRWOMAN SAVAGE: Thank you Mike. Now if you folks could please get really close to the microphones and speak louder. We're trying to make microphones louder; People can't hear. Okay, proceed.

MS. FULTON: All right. Will do. And thank you. And again, Lynn Fulton, the president at OSS Saint Joseph's Medical Center. You know, we're pleased to be here to request approval for the 15 ICU and 10 Med-surg expansion. OS of Saint Joseph, you know, really

through the pandemic transitioned from, what I would say, community hospital to a regional referral center. Over the last three years, we've accommodated close to 3000 transfers for inpatient care.

Over the last two years, we have had to turn down about 228 requests. So we feel we're really in the midst of some tremendous space. Our med surg stays have increased by about 5 percent annually over the eight years. Our ICU days increased by about 98 percent between 2017 and 2022. We've used the 20 bed 10 percent rule several times over the last few years to accommodate both that we could put the beds to the best use for patients.

In July, 2020, I put the cause to reclassify 11 swing beds two meds surg; into 2022, we closed our long-term care unit and transitioned those 12 beds to med-surg. And then last summer we added three beds for a total of 121 medical surgical beds. So you might ask in Illinois, what -- what's causing this. And it's really twofold.

Number one is the absence of a specialist in small rural hospitals. You know, at every hospital used to have general surgery, GI, neurology, available and on call and today that's just

not the case today. They're really relying on the regional referral centers to be able to take those patients. And we've even seen that increase over the last 14 months.

And then number two is a little more positive is really the population growth in Bloomington-Normal. Really attributed to building an electric car manufacturer. You know, most recently Dr. Zelig<ph> and I just met with some of their team and they're at over 8,000 employees today at that location in Bloomington. Our economic development group is projecting about 13,000 in population between 21 and 2028. And living in Bloomington-Normal you can't help but see in anecdotally the results of that.

You know, houses do not stay on the market long even in today's rate environment. In my neighborhood, I regularly see license plates, especially from California moving to the Bloomington-Normal market. Our schools -- our largest school in a rural community, They've added tailors to the back of the school to accommodate the increase in students. They also do virtual site halls now to be able to kind of expand their ability to have students.

Retail and our services in the

community also expanded as we've seen the increase in population. So we feel it's really important that we look at this now and we position Saint Joseph Medical Center so that we can continue to care for not only our community, but also the community; Thank you.

MR. WEBER: Thank you. Again. I'm Ralph Weber certificate of need consultant and I will address the negative findings. And first, I want to thank Mike and George for their consult during a pre-application conference on this project as well. And and while we were preparing the permit application it's always appreciated.

The first negative relates to Saint Joseph's Utilization of Medical Surgical and ICU beds. The staff analysis correctly reports that these volumes for the past two years justify fewer than the 15 ICU and 10 medical surgical bed increases that are requested. But our bed increases are based on projections utilizing the experience volume increases that have been cited for the past six to eight years, not just the past two. And ICU patient days have average increase of 20 percent per year during that period of time. And med/surg, is averaging 5.3 percent, taking the numbers that she got in annual.

And the population growth being experienced means that the continuation of this past growth is very likely.

The second negative finding is that our rapid population growth model did not consider birth and death rates. And that is also correct. I wrote the analysis using aggregate population growth driven mostly by the creation of 7,700 new jobs inside of 8,000. So I mean, every month this thing is increasing; new businesses supporting the electric vehicle industry and secondary growth in hospitality, leisure, and services add to this number.

Growth spur is spurring the population increases. I use the HSFRBs data on population distribution by age cohorts. And inpatient hospitalization rates by these aged cohorts, to protect future utilization associated with the population growth. These age cohorts -- cohorts factor in there some deaths. So I did not address births and death. But I did review the birth and death rates from McLean County; that also is fascinating. And because it was raised, I will address the record.

While births had been declining from 2014 to 2018, they have been relatively stable over the past six years. So by stable I mean that they

fluctuated up or down by less than a hundred from year to year, around a current level of 2100 births for this year. For death rates they peaked in 2020, likely due to Covid and have declined since. As a result, deaths, this year are about the same, within a dozen of what they were in 2017, just under 1400 a year.

Comparing now in 2017 pretty much takes out the Covid factor. Deaths this year are down more than 200 below the death count last year. Again, this is for a plain count. As upon this year of births exceeded deaths in the county by about 750.
And incidentally, the average yearly difference for the last six years, I'm sorry, last eight years, it's been 752 per year, births above death. It's a good story that continues and it attests to the population growth.

As to population migration inbound and outbound migration result in the net gain in populations. The source of the data is the US Census Bureau. Census flows mapper presenting U.S. county migration patterns. The census flows mapper presents two factors, inter and intra state migration. Outside migration of almost 4,800 residents from McClean County to two other states in the last five years ending 2020; exceeded the in migration of about 2,600 people from

other states to McLean County. In other words, there were about 2,145 people leaving above those arriving during these five years.

But over the same five years, if you look at migration within Illinois, there were over 9,100 people who moved into McClean County from elsewhere in Illinois, while about 600 left McClean County for other Illinois counties. So, movement within Illinois was a gain of over 3,100 people in this five years. Combining inter an intra state migration, there was a net gain of about 1,000 people; 993, the five years ending 2020.

So when I look at the same data for the five year period ending 2019 instead of 2020, the results were much the same with a net gain of almost 900 people. This shows a <unintelligible> in the positive net migration when a one year later timeframe is used. So in summary, the excess of earth's over deaths and the positive net migration reinforces the population data presented in the permit application.

So finally, the third negative relates to the cost of the project exceeding state standards. The cost of $561 per square foot for new construction is about $91 -- $90 above the RS standard. We reported on

some of the factors explaining the difference above the standard and thank Mike and George for including that in the state board staff report.

To have several factors adding to new construction costs include new construction in a tight courtyard to expand existing space. This requires smaller construction equipment and extra cost tie-ins to the existing of all structures and foundations. And number two, challenging conditions from material delivery and set up approach of the proximity of an adjacent building entrance. The modernization costs of $419 is about $90 above the standard for modernization.

Factors adding cost to modernization are the majority of modernization space being converted, that's been non-clinical. So as a result there are significant infrastructure deficits requiring against plumbing, HVAC, electrical, medical gases, and low voltage wire. And secondly, the existing space being modernized has difficult angular spaces, space layouts, columns, configurations requiring special architectural and construction efforts.

I have other comments, but I think we should take questions. As Mike noted, there was no opposition to the project, only letters of support

received from eight hospitals in Central Illinois. And as you thank you for this.

CHAIRWOMAN SAVAGE: Thank you. Our board member have any questions.

MR. BURNETT: I Have a question, I think it's for Ms. Fulton. And did, did you say that you had to -- you had to say no to about 2000 referrals?

MS. FULTON: 228.

MR. BURNETT: 228 or 2,228.

MS. FULTON: 228.

MR. BURNETT: Oh, okay. And that was for, because you had inadequate beds served or ICU beds available?

MS. FULTON: Inadequate beds, as well as a few of whom were for staffing.

MR. BURNETT: Okay. And can you comment on -- on your rationale for requesting 10 additional med surg beds and 15 ICU beds? Why 10, why 15?

MS. FULTON: Well because of the way that we're going to set up the unit, we'll have the 15 ICU and the 10 will be Med/Surg, but they'll serve as a step down capacity. So when a patient leaves that -- the ICU level of care, instead of having to go elsewhere in the building, we'll be able to have that continuity by

being able to move that patient to a med surg bed right there with the seat.

MR. CONSTANTINO: I may, I also, I asked this question when we started working on the permit application. But that's where the use of the 20 bed, 10 percent rule has come in and they've added, I think, 24 medical surgical beds over the last 30 years. So this is catching time for the ICU.

MR. FOX: Will the additional ICU beds be built the contiguous to or part of your existing ICU?

MS. FULTON: No, they, they will not. That's not feasible with the way that the building's laid out. So it will be a separate unit from our --

MR. FOX: And, and is part of the rationale for 15 ICU beds versus 12 or some other number because, because you're located in these beds and to have them there that it makes sense to have a critical mass of those beds for staffing purposes?

MS. CALLUTA: It's really both. For staffing as well as when we look at the projections for what we believe we're going to need for ICU beds, that number seemed to be the right number both for staffing as well as for future utilization.

MR. KAATZ: Will you be adding or expanding any

to your ICU related services? I get that your population is growing, but are you, would you be adding any new services? Do you expect to expand any of your care service?

MS. FULTON: We have been, we are just accommodating more for patients. An example is our OR, you know, in our OR recently met with our OR? General director about 3000 minutes in our OR last month. So our expansion for that is utilizing it more so increasing our hours of operations so that we can serve our patients. And so that's really what we've done throughout the hospital. How can we maximize what we have to be able to take care of the patients coming in for services.

We do have a plan though, you know, as we look and we continue growth, you know, where are those areas that we need to continue rolling, whether that's imaging, OR.

MR. KAATZ: Thank you.

CHAIRWOMAN SAVAGE: Mr. Budde.

MR. BUDDE: What are your projections for ICU beds in 2023.

MR. HOHUMIA: For 2023, the projected what?

MR. BUDDE: ICU bays.

MR. HOHUMIA: ICU bays. 2023. I'm sorry. I have so many numbers in this. I have, I've got three pages of notes and you asked about one it's not on. So 2023 chart ends at 2022.

MR. BUDDE: Yeah, you don't have any information in there, saw a big increase, 22,000 increase. And it's already, so you're down to 60 percent utilization now I'm just wondering what trend line might --

CHAIRWOMAN SAVAGE: When did the electric car company went that town -- to your area?

MS. CALLUTA: The tremendous road within really Rutherford really lasts for the last three years. They have been there, they started they lease the space, that was the Mitsubishi plant before came in at least -- I've been there six years and they had came on shortly after I joined Saint Joe's. And then they started to ramp up subsequently within the last three years that we've seen the biggest bump.

MS. CALLUTA: They have now 8,500 employees and 20,000 family members assisting in their medical needs. So it's a cycle service.

CHAIRWOMAN SAVAGE: Did they ramp up to 8,000 employees more recently, or --

MS. FULTON: We had the, I think 7,500 of the

application that went Dr. Zawa<ph> and I ended up with 'them about how we can continue to increase services try to help us with their members. That's when we get our 80,000

CHAIRWOMAN SAVAGE: That's kind of secret I guess. Moving to, I --

MR. WEBER: I have an answer for Mr. And apologize for not getting into at my fingertips, but there were in 2022 about 3,056 and we are scheduled to increase by about 574 patients a year. So that would put it at about 3600 - 3650 for 2023.

MR. BUDDE: That's reverse of the trend for 2021. 2022, yes. Yes. You're anticipating 500 more ICU bays in 2023?

MR. WEBER: Yes. Thank you.

CHAIRWOMAN SAVAGE: Just one question I would have is based on your increasing volume in med surg you think 10 is enough? I think the younger population are probably going to be working at that plant. Are going to be younger.

MS. FULTON: Which you are correct. We do feel that is adequate for today for our plan to expansion. We do believe that we will need to continue to increase, but we have a stepwise plan on how we want to

accommodate --

CHAIRWOMAN SAVAGE: Like the schools and going trailers.

MS. FULTON: Yes, exactly.

MR. KAATZ: I've noticed your length of stay is increasing. We have been trying to sort through. All the information. We have a growing community, but you, you don't have the admission numbers, which is why you have two negative findings, but you have a, you have a significant lack of stay issue. So I'm trying to figure out if growth being driven by the length of stay by admission. What's going on between the relationship between admissions and length of stay? That's my first question.

MS. CALLUTA: Well, you're correct on the length of stay and that we're not unique to that, that's happening in every facility across the country. It's harder to get patients into post acute care. Dr. Zalink is actually leading a project on reduction of length of stay because that's where we're hoping to generate some access capacity so that we can fill in and thus the requesting of the 10 bed med/surg stage. So we began to kick off that project actually two months ago where we can reduce that.

Now, your second part of that question is about admissions. As we look at the negative findings, really in the short term where we're looking at our growth over the next three to five years. With the population, we feel that we will hit what the state's requirement is, it's just not showing the population in the short term.

MS. FULTON: In addition to that, the -- the population growth is a factor. Also our staff is going to be very similar. So we're growing as a referral center as I said, changing from our previous state of community hospital to really regional referral centers a very important transition for us. And being prepared for that growth is going to be very important. We, again, don't want be a trailer bound.

MR. FOX: Would you have a medical ICU and a surgical ICU?

MS. CALLUTA: That's what we're -- we have not solidified that, but that's what we are looking at there. We're putting that new unit is right next to surgery. So it would make that very convenient for us.

MR. FOX: Do you have intensivists on staff?

MS. CALLUTA: We do. Yes I do.

MR. BURNETT: So about 30 percent of your beds

Would be designated for med/surg; That's a little high isn't it?

MS. CALLUTA: When You look at what's projected though. And when you read any of the literature, it's really for ICU which you see the aging demographic and increase morbidities that we're seeing. And what we see today is really following right along with that. In addition the surgical aspect, we've really grown our own thologic surgery at Saint Joe's. Unfortunately seeing more and more patients coming in with cancer. And treating more and more patients. And with that oncologic surgery you generally see that ICU level of care.

MR. FOX: Thank you. The member Kaatz said the medical surgical bed count would increase to 131 if this project is approved. And so the 30 I that's slightly under 25 percent, so it's really not pushing a third. Maybe that's not a substitute difference, but it's five.

MS. HENDRICKSON: I have a few questions. First and foremost full disclosure I'm from the Peoria area, so I'm very familiar with the location. I think a question I had, I think it was in reference to, is that the Mitsubishi plant, it closed effectively in 2019,

but it was fully operational in 2015. So you're collecting historical data to provide it demonstrates kind of a similar numbering that Caribbean would've had right now in terms of growth.

And so that along with potentially with the Covid spike in numbers, I'm having a hard time wrapping around the, the number of beds that you were adding above what was potentially recommended. And likewise looking 45 minutes the other direction, right? That's the different HSA area is Saint Francis Medical Center; a large area. So I was wondering what is their current, if you know, what their I think it's the percentage occupancy is right now?

MS. CALLUTA: It might take, I'll let Dr. Zai talking in the, in the moment as well. The Mitsubishi Caribbean -- Mitsubishi was really a fraction of what Rian is. They've increased the size and the scope of that facility. It doesn't even look the same if you go out on that campus today. And so I -- I want to say, and this recording Mitsubishi was maybe like 3000 employees. And so when you take that and compare that to Rivian at over 8,000, it is a large difference.

The other piece to that again is the regional referral center. The number of referrals that

we see, and you look at the graph historically at Saint Joe's, I mean, it, it is a, a rather steep line of what we're seeing come in. And so that's why I -- I tried to explain it. It's, it's really too big.

It's population growth, but it's also what we're seeing coming in from that outlining areas. Now, Saint Francis, I will tell you is full. Saint Francis is full almost every day. And so it's really incumbent on us as a sister hospital to be able to take those regional referrals that could come to a hospital our size so we can save Saint Francis for those patients that truly need that pulmonary care.

And Dr. Calluta, please.

MS. CALLUTA: Yeah, I would reiterate that I'm -- I've been the chief medical officer at Saint Joe's for five months, but I've been on staff at OSF Saint Francis Hospital in Peoria for 25 years. And I was their medical staff president so I have a lot of experience there and they are full to Gills. And pre pandemic, I remember we would have census about 99 percent, which is emergency status with no access. And they would try to find beds in any of our other hospitals. And B the, the most -- hospital and near there in our system is incredibly important for us to

have access for those patients. So we are we are not in habit of sending patients for intensive care to Peoria.

We, we will probably take patients that they can't take. So for an important sister hospital there a place that has almost don't have access to.

MS. HENDRICKSON: And then similarly you go the other direction, you hit Champagne-Urbana and what the kind of average occupancy rate of that?

MS. CALLUTA: And to my understanding not the regional referral center that, that we sort of think that, that we we're drawing a very sophisticated referral center that will accommodate patients made of our other regional facilities. And to my understanding, although I don't,.

CHAIRWOMAN SAVAGE: Besides in your general area, where are you drawing patients from then,.

MS. CALLUTA: Well, if you draw a line and look about 90 miles out obviously not from Saint Francis, but that generally within that level it's what we're seeing come in.

CHAIRWOMAN SAVAGE: Into Saint Joes?

MS. CALLUTA: We do see patients come from farther west of Peoria because Peoria is full. So

we'll -- we'll get patients from Galesburg, Keane from the region that would naturally go to Saint Francis geographically. But, but they're full.

MR. KAATZ: I would add that the patient origin table in the permit application shows that the McLean county is the source of 70 percent of the patients. And of that 70 percent, 55 percent come from four counties in the Bloomington Normal area. The other side of that coin is 30 percent of the patients come from outside McLean County, which is a big number. And McLean County is the largest county in Illinois.

And I was surprised to learn that it's almost a couple of square mile. Its the size of Rhode Island island. So coming from outside of McLean county, 30 percent of the people, they're coming a fair way.

CHAIRWOMAN SAVAGE: Other questions?

MR. FOX: How do you explain the cost issue?

MR. WEBER: Cost per square foot for construction and we're, we're $90 above on new construction and also $90 above per square foot on modernization. And the modernization is in an area that has a lot of angles. It's not all rectangular 90 degrees. And it's also part of the addition that's being built, the addition that's being built in a courtyard that's actually very small

and I think the new construction is 3000 plus square feet very small. So you got a lot of costs over small one square footage. The modernization of this whole building is also very difficult and that's the bulk of the square footage of the project and it's all nonclinical space. So it has to be upgraded for all of the codes and it's basically business and other nonclinical use right now.

CHAIRWOMAN SAVAGE: Other questions?

(No verbal response.)

CHAIRWOMAN SAVAGE: All right. Hearing none, George, if you could call the roll.

MR. ROATE: Thank you, Madam Chair. Motion made by Mr. Kaatz, seconded by Ms. Hendrickson. Mr. Budde.

MR. BUDDE: Based on the conversation today, I think I have a concern on the size of the ICU requests and doing the math; looks like it brought occupancy to 30-35 percent. So, I would vote no.

MR. ROATE: Thank you. Mr. Burnett.

MR. BURNETT: Yes, please.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: I'm going to vote yes and based on testimony today and I, I'll just add editorially that it's it's refreshing to have a, a downstate Illinois

applicant building some additional facilities. 'Cause We've seen a lot of places had to have to close down.

MR. ROATE: Thank you. Ms. Hendrickson.

MS. HENDRICKSON: I agree to vote yes based on today's testimony, but I would actually also echo my, my colleague that I think my concern is, while it is good to see the growth. I'm nervous about the size of growth, but yes.

MR. ROATE: Thank you. Mr. Katz

MR. KATZ: I will vote yes based on the presentation of the conversation. I I echo my colleagues as little concerned with the sizing of the project. But I think we we spent it a lot of time talking this, so I vote yes.

MR. ROATE: Thank you. Ms. Legrand.

MS. LEGRAND: I also vote yes, based on what I've heard today.

MR. ROATE: Thank you. Chairwoman Savage.

CHAIRWOMAN SAVAGE: I vote yes as well, based on state board staff report and and testimony today.

MR. ROATE: Thank you. That's six votes in the affirmative. One vote in the negative.

CHAIRWOMAN SAVAGE: This application is approved. Thank you and good luck. On to other business. Other

business and that includes John to talk about the authority summary, financial report of fiscal year 2023 and in the first quarter and fiscal year in the first quarter and fiscal year 2024.

MR. JONES: Thank you, Madam Chair. There are two documents before you today. The just of year end 23, the first quarter, I'd like to focus on just the year. Page one shows that we are well within our budget, we should be as we get those down. Before you go to page two, I direct you your attention to the bottom corporation for recruits seven 1.6 million on DBA support, 1.2 both sides, well not both sides are paid more out. So looking at patients two through four, we'll see that we are involved with both probations.

There will be two new staff members, Sherry and I <unintelligible>. We we're, we're trying to also add a legal counsel to the board. That position's not yet filled. So we'll be seeing the board side increase, have request for fiscal five that increases the corporation's budgets. That has not yet been approved. The department.

The the other thing that item we'd like to do legislatively is also get the board paid. Like upon not that site projecting forward, we

can afford that within our current appropriations. Like I said, a little bit of -- but we cant afford that if we if it is approved . So we are, we, so she have our funds strong at the moment. You always have to be careful that it doesn't get swept and by, by the program. So your I hope that answers your question has been happy. To answer your question, think.

CHAIRWOMAN SAVAGE: One of the things that stuck out me was that the spending costs. Last year was $94,000; now it's $90,000 for the first quarter. Where's that coming from?

MR. BUDDE: I believe that is money that I think must have put notices in newspapers. That is something that internally we've talked about many times. The majority of our projects are Change of ownerships. Put those, put those notices in the newspapers, especially in the Chicago market. Additional application, which is on, on several of these projects; It's all we get. So that is something that we are going to look at to pass out, maybe some of those costs or we see the increase additional application. Another possibility we've been discussing is instead of fee, all fees are captive, a hundred thousand dollars, maybe decrease the cap to a 100, 2,025, 50,000. Mm-Hmm, <affirmative>, why

keep affordable not looking to really change if there are any tweaks that <inaudible>.

CHAIRWOMAN SAVAGE: Other questions.

(No verbal response.)

CHAIRWOMAN SAVAGE: All right. Well, hearing none I want to wish everyone a very happy, healthy Holiday season and see you in 2024. So now may I have a motion to adjourn this meeting?

MR. FOX: So moved.

MS. HENDRICKSON: Second.

CHAIRWOMAN SAVAGE: All in favor say aye. Aye.

MR. BUDDE: Aye.

MR. BURNETT: Aye.

MR. KAATZ: Aye.

MR. KATZ: Aye.

MS. LEGRAND: Aye.

CHAIRWOMAN SAVAGE: Okay, good. The meeting is adjourned. Our next meeting is on January 23rd, 2024 here at Bolingbrook Golf Club. Thank you. Happy holidays everybody.

(WHEREUPON, the above-entitled proceedings were adjourned until, January 24, 2024.)

STATE OF ILLINOIS.)
) SS:
COUNTY OF COOK)

I, Michael Marciniak, CER, Notary Public, electronic reporter doing business in the State of Illinois; reported the proceedings that were held on the date, time and place set out on the title page hereof; and that the foregoing is a true and correct transcript of report of proceedings so taken aforesaid.

I further certify that I am not related to any of the parties, and I have no financial interest in the outcome of this matter.

Michael R. Marciniak

MICHAEL R. MARCINIAK.
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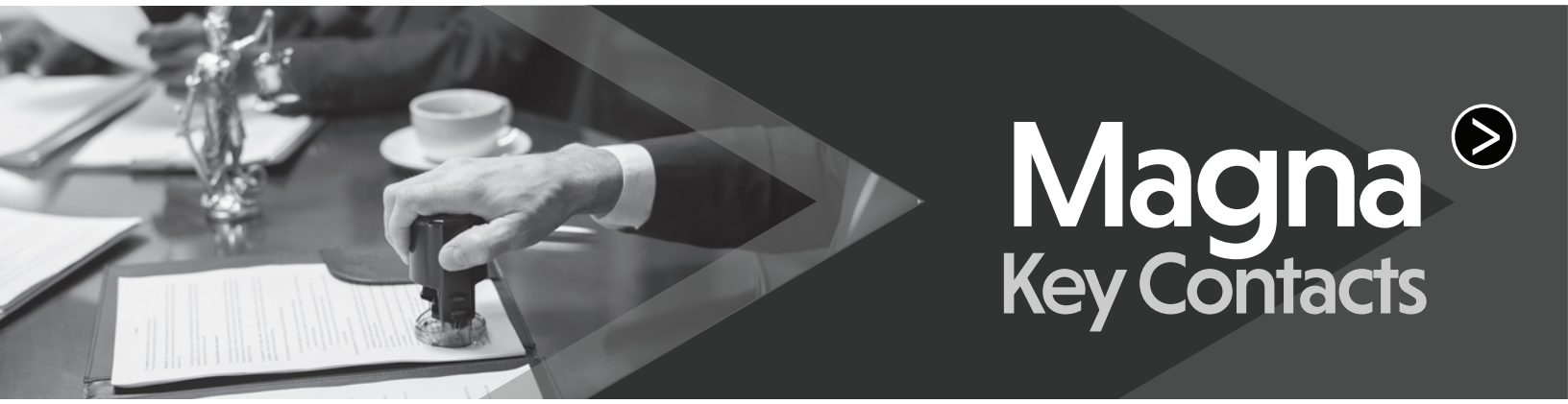
Notary Public



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