Transcript of Open Session Meeting

Date: May 9, 2023
Case: State of Illinois Health Facilities and Services Review Board

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ILLINOIS DEPARTMENT OF PUBLIC HEALTH

HEALTH FACILITIES AND SERVICES REVIEW BOARD

Open Session

Tuesday May 9, 2023

8:57 a.m.

Job No.: 476962

Pages: 1 - 156

Transcribed by: Janine Thomas

Proceeding held at the offices of:

2001 Rodeo Drive
Bolingbrook, Illinois 60490

Pursuant to agreement, before Brianna Bramlett, Notary Public in and for the State of Illinois.

A P P E A R A N C E S

BOARD MEMBERS PRESENT:

Debra Savage, Chairwoman
Antoinette Hardy-Waller
Gary Kaatz
Dr. Audrey Lynn Tanksley
John P. Kniery
Douglas Doran, Do
Monica Legrand
Rex Budde
Dr. Sandra Martell
David Fox
George Roate, IDPH Staff
Don Jones, IDPH Staff

Members of the Public:

John Wieland
Dr. Keith Knepp
Mary Thompson
Scott Sorell
Sharon Addams

A P P E A R A N C E S

(Continued)

Members of the Public:

Samuel Sears

Sheryl Crow

Victor Chan M.D.

Debbie Trau, RN

Lacey Walloa

Dawn Lochem

Matthew Jackson

Sydney Meuth

Mark Jones

Dr. Imran Shakir

C O N T E N T S

P R O C E E D I N G S

CHAIRWOMAN SAVAGE: I'm going to go ahead and call the meeting to order. And -- seems to be missing, so we'll just call this ready to go. No problem, George. And now for the official start. And I want to wish everybody in here, we'll have -- a very happy nurses week. And if you happen to be a teacher, happy teachers week. I happen to be both, as is my friend Mona.

All right. So I would like, as I say, to call this meeting to order. Please be aware that these proceedings will be transcribed by the intending court reporter pursuant to law and the rules [ph]. Now, may I have a motion to approve the May 9, 2023 meeting agenda?

BOARD MEMBER: So approved.

CHAIRWOMAN SAVAGE: Do we have a second?

BOARD MEMBER: Second.

CHAIRWOMAN SAVAGE: Okay. All in favor say aye.

MULTIPLE SPEAKERS: Aye.

CHAIRWOMAN SAVAGE: Aye. Any opposed?

So that actually has passed. Now we have a motion to approve the March 21, 2023 meeting transcript.

BOARD MEMBER: So moved.

BOARD MEMBER: Second.

CHAIRWOMAN SAVAGE: Thank you. Any changes or comments? Okay. All in favor, if you can say aye.

MULTIPLE SPEAKERS: Aye.

CHAIRWOMAN SAVAGE: Aye.

Any opposed? All right.

So Don, would you like to call our roll today?

MR. JONES: Thank you, Madam Chair.

Mr. Budee.

MR. BUDDE: Present.

MR. JONES: Mr. Brunet [ph].

Mr. Fox.

MR. FOX: Present.

MR. JONES: Mr. Kaatz.

MR. KAATZ: Present.

MR. JONES: Ms. Legrand.

MS. LEGRAND: Present.

MR. JONES: Dr. Martell.

MS. MARTELL: Present.

MR. JONES: Ms. Hardy-Waller.

MS. HARDY-WALLER: Present.

MR. JONES: Dr. Tanksley.

MS. TANKSLEY: Present.

MR. JONES: And Chairwoman Savage.

CHAIRWOMAN SAVAGE: Present.

So now, Don, if you would like to begin with public participation.

MR. JONES: Thank you, Madam Chair. The open meeting that requires that any person shall be permitted an opportunity to address public officials under the rules established and recorded by the public body in an effort to balance the rights of individuals who would like to address the Board with the Board's need to maintain meeting decorum and efficiencies, the following guidelines have been developed.

Number one, each speaker will be allotted a maximum of two minutes to provide their comments. Number two, all comments must relate to board matters and should not repeat comments previously submitted to the board. Number three, anyone requesting an opportunity to provide comments at a board meeting should preregister at least 24 hours prior to the scheduled board meeting. Number four, comments should not be disruptive, interfere with efficiencies of the Board proceedings or otherwise interfere with the decorum of a board meeting. Number five, speakers may not read testimony on behalf of someone who is not present at the board meeting.

Number six, the order in which speakers may provide comment will be determined on a first come, first served basis, and as listed on the current day's agenda. Board staff will announce when speakers may begin their comments, the use of visual aids or handouts is prohibited during the public participation portion of the board meeting. Number seven, you must conclude your comments when signaled by the board chair or board staff. Thank you, Madam Chair.

CHAIRWOMAN SAVAGE: Thank you.

MR. JONES: The first person who is registered to speak before the Board is John Wieland. Our next person is Keith Knepp, Mary Thompson, and Scott Scorell.

UNIDENTIFIED SPEAKER: You can begin when you're ready and just say your name for the record and spell it.

MR. WIELAND: Okay.

UNIDENTIFIED SPEAKER: Thank you.

MR. WIELAND: Good. Greetings. My name is John Wieland, W-I-E-L-A-N-D. I addressed this board ten months ago as chairman of the Methodist health Service Corporation. I shared with you our EDI statement. And I focused on the three words of that statement that are so important, inclusiveness, dignity and respect.

The people -- that we focused on that day were children and adolescents with mental and behavioral health challenges. I said that the foundational strength of any society is how we come alongside the hurting, and how we need to do better by providing any healing to these children and their families. And each of you graciously supported our cause. Thank you, again.

It was Board Woman Savage who asked when are you going to come back and talk about adults. And I said, about a year or so. I'm so happy it's only ten months. Adults with mental and behavioral health challenges they have also been marginalized and ostracized and often forgotten. And we have to do better for them as well.

We are thrilled that others are wanting to step into this space and make a difference. We provided a letter of support. The unique aspect of this CON is that one organization is a for profit with 80% interest and OSF, a not for profit with 20%. Neither of those are bad in itself, but by definition, there is a difference in the mission. And it may have a conflict when serving this vulnerable people group we're trying to serve.

Keith and Mary will share some of the requests we have to make sure that we serve adults with special behavioral and health needs with inclusivity and with dignity and respect. Thank you.

MR. KNEPP: Good morning, I'm Dr. Keith Knepp. I'm president of Carl Health and it's spelled K-N-E-P-P. Thank you gentleman. Thank you as board members for your service. You've known us before as Unity Point Health Central Illinois. We're the same organization in the Peoria region. We're now part of an Illinois based not for profit health some -- health.

As Mr. Wieland noted, I'm here on behalf of the volunteer community board members who make up our board. Our expansion of child and adolescent beds through the -- center which you approved last year is well underway. Completion of that facility adds 35 new beds. The -- available today. That includes the opportunity for -- for us to add 14 new adult behavioral health beds at Methodist representing expansion of both child and adolescent and adult beds for the community. We remain committed to serving those patients as you heard.

Despite the fact that the impact of this expansion is not yet known and won't be known until well

into 2024, we're supportive of the Meadowview application. So long as the conditions noted in our April 17th letter are address ed by the Board. We've also reached out directly to the Meadowview applicants with an offer to collaborate and to best serve the needs of our community.

It's critically important that all the providers of behavioral health services in our community are committed to caring for patients regardless of their ability to pay or the challenges of their specific diagnosis. And whether they're a for-profit entity or not.

Therefore, we are asking that conditions be imposed on Meadowview Hospital as part of the approval process which -- thank you.

MS. THOMPSON: Good morning, my name is Mary Thompson. I appreciate the opportunity to speak with you today. My last name is T-H-O-M-P-S-O-N. I am the president of Trillium Place, an affiliate of Carl Health. And I am privileged to work for a nonprofit entity with a vision to provide world class behavioral health and substance use disorder services for all populations from children to seniors.

Trillium Place's mission is to build an

integrated care model to meet the needs of our entire community. I am also here to be the voice of my volunteer board. As stated by John and Dr. Knepp, we appreciate that others have decided to step up to meet the needs we have in our community as we have been doing since 1954.

However, because the applicant is a for-profit entity it is crit ical the HFSRB impose conditions to ensure the commitment articulated in the application are met and sustained. We respectfully ask the applicants to commit to implementing the OSF charity and financial assistance policy at the new for-profit hospital.

We respectfully ask the applicants to fully participate in the Illinois Medicaid Program by entering MTMCO agreements and accepting Medicare -- Medicaid beneficiaries without limitation or treatment at Meadowview Hospital. We respectfully ask the applicants to commit to caring for patients with a history of violent behavior or a significant risk for such and for patients with severe and persistent mental illness who require inpatient psychiatric acute care.

We respectfully request that the applicants describe in more detail how they will proactively collaborate with Methodist, another existing service

provider in the community. Again, thank you so much.

MR. SORREL: Good morning, my name is Scott Sorrel, S-O-R-R-E-L. I'm the -- administrator. I also was here before you ten months ago in support of the -- project. Today I'm here on behalf of the County of Peoria -- Peoria County Board, we strongly support the application before you.

Our community, like many, faces significant behavioral health challenges driven by a shortage of behavioral health infrastructure. Concurrently, poverty, violence, substance abuse and the ongoing impacts of Covid-19 are stressing our existing infrastructure while we also -- are also experiencing an increased need for those services.

Both healthcare providers in the community currently transport a significant number of their patients to facilities outside our region. If -- patient for example, it is most likely to be in a U.S. health -- facility here in suburban Chicago, the director -- partnership between the co-applicants.

This long distance solution, however, is not the best solution for our community's needs. As I've witnessed firsthand in the last 12 months -- being acute inpatient care with no facilities available in our

community.

This alone demonstrates a need for inpatient beds at -- two plus -- south of where we sit today. To accentuate this point, we want you to think about the positive impact for both the patient and the patient's support network this project will have by being in our community.

Finally, as we heard from the other speakers so far this morning -- West Healthcare hasn't -- as part of its mission to serve the underinsured and uninsured. In many cases these patients need behavioral health services even more than those of us with financial means through insurance or our personal wealth.

Having Meadowview Behavioral Health possible in our community will start to address this community deficit. The County of Peoria is proud to support this project. Our community needs increased access to essential behavioral health services as a community partner, we strongly believe this project will fulfill -- need. Thank you.

MR. ROATE: Our next four participants are Sharon Adams, Cheryl Crow, Dr. Samuel Sears, and Dr. Victor Chan.

CHAIRWOMAN SAVAGE: You can state your name

and spell your name, please.

MS. ADAMS: Good morning, my name is Sharon Adams, A-D-A-M-S. I am the CEO of Heartland Health Services in Peoria and also a resident in Central Illinois. I'm in today to speak in support of Meadowview Behavioral Hospital in Peoria.

Our community faces significant challenges when it comes to addressing behavioral health issues for adults and children. Heartland Health Services is a Federally Qualified Health Center in Central Illinois with six medical clinics in Peoria and two in Pekin.

We are a nonprofit organization that receives federal funding and reimbursement to provide medical services to the medically underserved areas and populations. We have been in the community for 32 years. We see approximately 21,000 unique patients and 65,000 encounters annually. Our payer mix is approximately 70% Medicaid. Heartland has collaborated with OSF HealthCare for many years, specifically with four residency programs in Peoria.

The results of a pre-Covid research project indicated that 25% of our patients had a significant mental illness diagnosis. And another 25% had a minor mental illness diagnosis. Post-Covid, these percentages

have only increased. Of important note is our psychiatric appointments for new patients are now being scheduled four months out. Heartland patients who seek out behavioral healthcare at local emergency rooms could be detained for days in the emergency room waiting for acceptance into a behavioral health program. Often miles from home.

This new behavioral hospital project will fulfill this great need. Please approve this project as it is very worthy and especially important to our community, patients and residents. Thank you.

MR. SEARS: Good morning, my name is Samuel Sears, M.D., S-E-A-R-S. I'm the consultant psychiatrist for St. Francis Medical Center in Peoria as well as the director physician services for Behavioral Health Services -- OSF Medical Group. I'm also a resident of the Peoria area, and I'm here to support Meadowview Behavioral Hospital.

Our community has suffered from a shortage of beds for many years which has only worsened over time. Multiple referral hospitals have closed resulting in patients having to go further distances with increased challenges for continuity of care. Hours spent searching for beds takes away from our ability to see

other patients at times of ever higher volumes, exacerbating waits and the access issues.

On the back of this, higher placement makes aftercare and transfer greater challenges than it already is. Limits ability for friends and family to participate in care plans, and increases risk for care plan failure. Watching the daily disappointment in patient's faces as we explain the realities of placement. Between the time it takes to find the placement and distance -- has never ceased to be heart breaking over all of these years.

Patients are in need of real help and this project can provide that closed element [ph]. Please approve this project to support our community and our patients. Thank you.

MS. CROW: Thank you, I'm Cheryl Crow. I'm the vice president of behavioral health for OSF HealthCare. We see over 20,000 patients per year for behavioral health needs. We found resources for some of these individuals, but a lot of them were very dependent on our primary care physician group to support, use our emergency room, and that's how they access resources at this point.

This new facility will enable us to connect

with a much greater number of patients that behavioral healthcare is greatly needed for in a very timely manner. It will consist of both inpatient and outpatient resources and this has not been available in our community for many years. We cannot wait for the opportunity to -- care for individuals who greatly need this service, so please approve Project 23-008 and thank you for your continuing support of our communities.

MR. CHAN: Good morning, my name is Victor Chan, C-H-A-N. I'm an emergency physician and I also serve as a chief of emergency services at OSF HealthCare St. Francis Medical Center.

I'm a resident in the Peoria area. I'm here today to speak in support of Project Number 23-008 Meadowview Behavioral Hospital in Peoria. Our community faces significant -- so addressing behavioral health issues for adults and children. In the emergency department, we often encounter patients seeking help for critical mental health concerns. Since we have a tremendous unmet need for psychiatric services in our area, patients are often faced with long delays to their needed treatment when trying to find a bed in an existing facility. Meanwhile, the emergency department can be very intimidating and anxiety provoking during

this critical time which may result in further deterioration of their underlying conditions.

Patients, friends and family are also strained during the lack of access -- due to the lack of access for psychiatric services in these situations. Beds that do become available may displace patients with multiple hours away from patients' homes and their support systems which -- anxiety causes stress for all those involved.

Having access to a local behavioral health facility will minimize delays in treatment and allow treatment for patients to be near their homes. Furthermore, subsequent emergency department resources can be further redistributed in order to care for and reach more patients in the community.

This new behavioral hospital project will fulfill this great need. Please approve Project Number 23-008 as it is much needed and a very important service to our community and residents; thank you.

CHAIRWOMAN SAVAGE: Thank you.

MR. JONES: The next four participants are Dr. Matthew Jackson, Lacey Walloa, Debra Trau, and Dawn Lochem.

MS. TRAU: Good morning. My name is Debbie

Trau, T-R-A-U. And I am the emergency department nursing director at OSF HealthCare St. Francis Medical Center. I'm also a resident in the Peoria area. I'm here to speak today in support of Project Number 23-008, Meadowview Behavioral Hospital in Peoria.

Everyday in our emergency department we are serving patients and families in a vulnerable state of being. The mission of OSF HealthCare is to serve persons with the greatest care and love in a community that celebrates the gift of life. It is a privilege to serve those who come to us. However, when a patient needs inpatient psychiatric care, we provide supportive care while we search for an acceptance at an inpatient facility. This often takes hours into days and at times into weeks with the patient remaining in the emergency department.

The ED environment is not favorable especially for this patient population and could potentially be deemed detrimental as we are unable to control the noise, the sites and the lights within the department. The lack of behavioral health services, particularly inpatient treatment is concerning especially when you have a patient with a medical health diagnoses such as dementia, cerebral palsy, diabetes in conjunction with

their mental health issues.

In these situations, the challenge to find placement grows significantly. We need to have more inpatient psychiatric beds available locally to help improve our treatment for our patients and their families. Family and friends' support during the treatment is a crucial element to success for these patients.

When we transport our patients out of town, it adds struggle of distance, lost wages, travel expenses and relationships. This new behavioral health project will fulfill the great need. So I'm asking you as the Board to approve the Meadowview Behavioral Hospital Project and thank you for your time.

MS. WALLER: Good morning, my name is Lacey. Wall, W-A-L-L, RN. I'm a nurse manager at OSF HealthCare and I support the CO [ph] application submitted for Meadowview Behavioral Hospital. Everyday we are challenged -- resources for behavioral health families and we need to collectively do better for these patients and their families.

This type -- and allow the access to healthcare regardless of their ability to pay. All too frequently our -- patients who need -- healthcare and --

MR. ROATE: [Inaudible] can you pull up closer, so we can hear you?

MS. WALL: This population is the most vulnerable and they're lacking access to healthcare regardless of their ability to pay. All too frequently, we are moving patients who need behavioral healthcare in the ED for days due to the complexity of their needs, ability, to pay, and -- availability.

Support and resources need to be local for our patients, especially those who lack the financial resources to pay for care and for their families to travel afar. There's a dire need for Meadowview Behavioral Health Hospital to help service this vulnerable population, a service that can help set the patient up for success. I ask that you approve the Meadowview Behavioral Health Hospital -- thank you.

MS. LOCHEM: Good morning, my name is Dawn Locheaum, L-O-C-H-E-A-U-M. And I am the manager of behavioral health at OSF St. Francis Medical Center. I am here today to speak in support of Project Number 23-008, Meadowview Behavioral Hospital in Peoria.

As a manager of behavioral health over 17 years, I have seen directly the consequences from losing long-term and short-term behavioral health treatment

facilities in our own community as well as in the state of Illinois. I have witnessed facilities closing down as well as those who scale down on services and a number of mental health beds available for patients. I have witnessed this and yet the increase in need and the mental health demands have grown tremendously and become more acute over the last two decades.

This void has created internal struggles for OSF St. Francis Medical Center and a wide array of difficulties for our patients and the community we serve. When we don't have enough mental health beds within our own community, this leads to patients and their families having to be transferred far from their home and everyone that they know. This leads to a -- days even weeks in the emergency department while on the medical floors at St. Francis Medical Center. While we wait for appropriate mental health disposition.

We provide our parents with the best -- we provide our patients with the best care possible, but ultimately they're not -- psychiatric facility. Long stays in the ED and on -- adds time they could be receiving comprehensive psychiatric services and treatment and appropriate placements.

This puts significant strain on family and

friends and -- their ability to play an active role in the care of their loved one and then can cause the patient to feel even more isolated and then impact their treatment. This also adds significant cost to the patient and family as trips and loss of support is substantial when we are sending our loved ones potentially -- thank you.

MR. JACKSON: Good morning, my name is Matthew Jackson, J-A-C-K-S-O-N. I am an emergency physician in the Peoria area -- OSF HealthCare system. I'm also a resident in the Peoria area. I'm here today to support the -- Project Number 23-008 -- hospital in Peoria.

Our community faces significant challenges when it comes to addressing behavioral health issues for both adults and children. The area is plagued today by poverty and violence and there is a direct link, behavioral and health issues that we in the community are experiencing. As an emergency physician, I can attest that behavioral and mental health issues are on the rise in the Peoria area. And the need to adequately meet these patients with appropriate care is growing.

In our current state, patients present in the emergency behavioral and mental health concerns typically face extremely long wait times for transfers

to inpatient and psychiatric care. While the emergency departments can provide a safe space, they're not equipped or staffed to provide appropriate care long-term for these patients to transfer beds, they're taking up to two days to complete.

In addition, patients are frequently transferred to facilities some distance from our local communities. Not only does this present a transportation challenge to patients returning to our area -- it lends to isolation from their support base and needs to be -- this in turn leads to -- further deterioration of their mental health conditions.

Often these patients end up becoming -- 911 services in our area due to a lack of other resources. EMS and law enforcement personnel while generally well intentioned lack the expertise in their -- to effectively handle these types of emergencies. These call for -- associated prolonged -- resources relying on multiple responding units. This placed further strain on our EMS system and other EMS systems already suffering from limited resources and personnel shortage. Finally, out of town transfers of mental behavioral health patients often -- to affect these transports. This further stretches already -- resources that leads

us to -- from our local 911 crews.

In closing, there's a palpable need for increased behavioral health resources. This new behavioral health hospital will fulfill this need. We absolutely -- project that will take -- that is important for our community and our residents.

CHAIRWOMAN SAVAGE: Thank you.

MR. JONES: The next participants are Peter Kohn [ph], Dr. Imran Shakir, Mark Jones, and Sydney Meuth.

MS. METTH: Good morning, my name is Sydney Metth, M-E-T-T-H. And I'm a resident of Peoria. I'm 100% in favor of the Meadowview Behavioral Hospital. There's currently a desperate need for this facility in our community.

On April 19th of this year I had a severely depressed episode that required emergency inpatient -- I had spent the last three years dealing with the repercussions of my husband ending his own life. I avoided help, because I needed -- the resources did not exist in my area.

I went to Methodist Emergency Room in Peoria, spent the next 16 hours waiting for an open bed in a facility. My mom stayed with me, afraid of not knowing

where I was going to be sent after 16 hours of wearing plastic clothes, being afraid and confused, I was loaded up in a patient transport vehicle with a barricade between me and the driver.

I felt like a criminal being shipped away from home and I only wanted help. I was sent three and a half hours away from home to Lake Behavioral in Waukegan. The facility was helpful, but everything was unfamiliar. I was not able to relate to anyone due to people from a different area.

The first few days I was there, I felt like I was recovering from just the emergency room and transport experience. I was at the lowest point in my life and had to spend it away from everything I knew. I was not able to have any visitors or any clothes besides what I wore to the hospital due to distance from my family.

I know that if this ever happened to me again, I would love to know that my home town in Peoria had my back. That I didn't have a -- to help me anyone else struggling with mental health issues. I -- living fear in case this happens again. No one should have to deal with going across the State to get preventive or emergency medical help. Peoria is currently a desert

for mental healthcare. And I feel that Meadowview has the chance to be an oasis. Thank you for your time.

MULTIPLE SPEAKERS: Thank you.

MR. JONES: My name is Mark Jones. It's J-O-N-E-S. Thank you Madam Chairwoman and the Board for the opportunity to speak today.

I'm from a small town outside of Peoria called Eureka, Illinois. According to -- Illinois, 20% of adults in the state will experience mental illness this year alone. I'm already one in five having been admitted to CBH -- my first experience. The services there far exceeded my expectations and put me into a new daily routine that helped me recover quickly.

The contact [ph] sits about three hours away from my wife and children. Peoria, Illinois is known for its great health networks, but currently lacks adequate mental health systems. My overall experience at CBH was great, but I want to address these three points.

One, the length of time -- because of -- because of the transfer, it was almost 96 hours for me to get signed to a care team. That time could be greatly improved. My father has Parkinson's and had a lengthy stay last November because the beds were full

for behavioral patients.

Two, the distance hindered family communication and support. Family is crucial to recovery. My wife took days off work and time away from our children traveling. And three, the cost is extremely high for travel. We are blessed with the means to do so, but understand that many don't. The increased risk -- for the patient being so far away.

CBH was a great resource for me when I most needed it. The Peoria area already being -- needs better mental health resources. Please approve Meadowview Behavioral Hospital.

MR. SHAKIR: My name is Dr. Imran Shakir, S-H-A-K-I-R. And I am a practicing adult child and adolescent psychiatrist. I am the chief medical officer at Chicago Behavioral Hospital and Silver Oaks Behavioral Hospital.

I have devoted the majority of my career to the Medicaid population. I am proud to -- a career that 90% of the patients that I have personally served are either unfunded or underfunded through my work at the hospital and various FQHCs in the --

I have the unique experience of directly providing care to the patients that we're all gathered

here to advocate for. We would be hard pressed to think of an individual more vulnerable than someone with a severe mental illness experiencing an acute crisis. Of these, some are trying to come to terms with suicide attempt that they just survived. Others are having difficulties establishing what is real and what is not as their mind fails them. Many of our patients are traumatized and -- to more adversity in the day than perhaps I have seen in my entire life.

Thousands of citizens from the greater region of Peoria find it all too difficult to find the life saving psychiatric care in this -- to add to their burden by -- away from loved ones is cruel and inhumane. And even more so, we have a great solution right before us. The burden is further bored by our treatment teams in the hospitals who then struggle correcting these patients with care in communities so far away. There are times that we have spent weeks stabilizing a patient only to realize the outpatient care is unreliable -- in the area there to return.

This brings me to my final point. Allowing the opening of this facility will not only allow extremely vulnerable patients in crisis -- as well as -- care, and also -- other community programs can develop

where they can continue care. I humbly implore you to approve this project and thank you for listening.

CHAIRWOMAN SAVAGE: Thank you.

MR. ROATE: Madam Chair, that's all the individuals who registered to speak.

CHAIRWOMAN SAVAGE: Thank you. May I have a motion to suspend the rules and amend the agenda to consider Project Item H-038 under Item 7 as next? May I have a motion?

BOARD MEMBER: So moved.

BOARD MEMBER: Second.

CHAIRWOMAN SAVAGE: All in favor say aye.

MULTIPLE SPEAKERS: Aye.

CHAIRWOMAN SAVAGE: Aye. And any opposed? And hearing none, we will move that to Item A. Item A of Number 7. Okay. So now we have the following 12 items under agenda listed, items approved. And so please let the record note that these items are as approved.

And now we will move to permit removal requests. And first on the agenda will be HS03, Project 23-008, Meadowview Behavioral Hospital. May I have a motion to approve Project 23-008 where we establish an acute mental illness specialty hospital in Peoria.

BOARD MEMBER: So moved.

MULTIPLE SPEAKERS: Second.

CHAIRWOMAN SAVAGE: Thank you. And so folks from Meadowview would like to come up and please be sworn in and identify yourselves. Identify yourselves and be sworn in. So if you'd like to begin by again identifying each of yourselves, spell your last name and then you'll be sworn in. Please grab the microphone.

MS. CONG ER: Good morning, my name is Michelle Conger, C-O-N-G-E-R. I'm the Chief Strategy Officer for OSF.

MR. WEBBER: Ralph Webber -- Consultant.

MS. SZE: Martina Sze, Chief Development Officer, US Healthfest [ph] -- last name S-Z-E.

Mr. KRESCH: Richard Kresch, CEO of US. Healthfest. Last name K-R-E-S-C-H.

MR. SEARS: Dr. Samuel Sears, S-E-A-R-S, of OSF St. Francis Medical Center and -- behavioral health for Medical Group of OSF.

MR. DAVIDSON: Brandon Davidson, CEO of Chicago Behavioral Hospital. Last name is spelled D-A-V-I-D-S-O-N.

MR. HOHULIN: Mark Hohulin, H-O-H-U-L-I-N -- vice president of -- OSF HealthCare System.

MR. SILBERMAN: Mark Silberman, Benesch, Friedlander. S-I-L, B, as in boy, E-R-M-A-N.

THE COURT REPORTER: If everyone would raise your right hand.

Whereupon,

Michelle Conger, Ralph Webber, Martina Sze, Richard Kresch, Samuel Sears, Brandon Davidson, Mark Hohulin, Mark Silberman,

being first duly sworn or affirmed to testify to the truth, the whole truth, and nothing but the truth, were examined and testified as follows.

CHAIRWOMAN SAVAGE: Thank you. Okay. George, would you please give us our State Board -- report.

MR. ROATE: Thank you, Madam Chair. The applicants propose the establishment of a 100 bed adult behavioral health hospital in Peoria, Illinois. The cost of the project is 34.3 million dollars with an expected completion date of December 31, 2025.

The proposed facility will provide a continuum of inpatient and outpatient behavioral healthcare, primarily for adults. The Board staff found two -- report two negative findings in Criteria 1110 that being a planning area in need and unnecessary duplication of service. Thank you Madam Chair.

CHAIRWOMAN SAVAGE: Thank you, George. Okay. If you'd like to proceed.

MS. SZE: Good morning. I'm Martina Sze. Chief development officer for US Healthfest. Thank you for the opportunity to present our project to build a behavioral hospital with 100 and -- 100 acute mental illness beds in Peoria with our joint venture partner OSF HealthCare.

I represent an overview of the project followed by Dr. Kresch who will talk about our commitment to care as already demonstrated at our three Chicago hospitals. Nationally, almost one in four Americans struggles with a behavioral health disorder. Mental health was identified as the number one health concern. In the community health needs assessment in Peoria, Tazewell, and Woodford Counties.

About 5,000 adult residents of our planning area HSA 2 were hospitalized in 2021 with the behavioral health conditions. Of these 5,000, almost 2,000 left the planning area for inpatient AMI [ph] care. An additional 300 with behavioral health needs received inpatient care in a medical surgical bed. That's 45% of inpatients residing in the area who did not get care in an AMI bed, in their area.

As we have heard in earlier testimony, many of these patient s had to travel over 100 miles for inpatient care, a major hardship. Residents in Central Illinois deserve better. Patients with mental health are some of the most marginalized and vulnerable populations we care for daily. And the behavioral health services are essential services that can and should be provided locally with inclusion, dignity and respect.

There have been widespread closures of AMI units throughout Illinois. With 13 units having closed in recent years. Nine of these units are in down state Illinois. These 13 units had a total of 252 beds where AMI care is no longer being provided. The announced closure of the AMI service at HSA St. Mary's hospital in Decatur will be the 14th. And will add 56 beds to the 252 which increases the number of AMI beds closed to over 300.

The large volume of patients traveling to the Chicago area and elsewhere to get access, to get care is evidence that there is an access issue in Central Illinois, and it is getting worse. HSA2 has a population of 647,000 with a closure of AMI units at McDonough District Hospital and Galesburg Cottage

Hospital, there are just three hospitals with AMI units in the service area. With a total of 112 operating AMI beds which equals just 17 AMI beds per 100,000 population. Which is almost half of the state average of 32 beds per 100,000. And far less than the recommended ratio of 40 to 50 beds per 100,000. This ratio will shift higher when the Young Minds Institute beds go online.

Finally, we have gained -- garnered significant support for this project. In addition to the 36 physicians, agencies, FQHCs and counselors who provided letters of commitment to refer patients, there are over 60 people who took the time to write in support of the project. No public hearing was requested and no letters of opposition were submitted. I now introduce Dr. Richard Kresch, CEO of US Healthfest.

MR. KRESCH: Good morning. And thank you for hearing us.

MR. ROATE: Could you speak -- could you speak up, please?

MR. KRESCH: I am pleased to return to this Board. During the past nine years, it has been my privilege to be here when this Board approved three US Healthfest projects in the Chicago area. They are

Chicago Behavioral Hospital and -- Lake Behavioral Hospital in Waukegan, and Silver Oaks Behavioral Hospital in New Lenox. The joint venture was --

I see that this is a new board with no members from the prior boards that considered our previous three projects. Like this project before you today, none of those projects encountered any opposition. We have successfully developed each hospital on time and -- in order to provide access to quality behavioral health services to patients across Illinois.

Each of these hospitals has added beds under the State's 10% pool [ph] since they were approved. In total, there are now over 400 -- beds at these three hospitals. We are growing with one of our facilities -- 90% of our annual occupancy --

We are helping the -- an essential need for mental healthcare in Illinois. These three hospitals treat all patients regardless of ability to pay which is a core port of our mission. Chicago Behavioral Hospital and Lake Behavioral Hospital have a Medicaid mix of over 60%, and Silver Oaks Behavioral Hospital has Medicaid -- 40%.

The key to our service -- is that each of our hospitals has units provided in full continuum of

specialized behavioral health services. Our patients are not generic, but require individual attention, so our units are organized around adult psychiatry, senior adults, adolescents, dual diagnoses, women only, military and so on. And it's hard to deliver such specialized services in smaller 20, 30-bed AMI units.

The size of our hospitals establishes a critical -- and patient volumes that enable the offerings of specialization and the scale to attract providers to work in the hospitals. We are thrilled to have formed a partnership with OSF HealthCare. OSF has an established network of 14 hospitals in -- four of these are critical access hospitals. OSF is one of the largest providers of Medicaid services in the state. We look forward to the joint venture -- on this project.

Before turning the mic over to Michelle Conger, I had to add a comment to Martina's statements about the need for care in Central Illinois. Last year almost 1,100 patients reside south of metropolitan Chicago were hospitalized for AMI at our three hospitals in suburban Chicago. In fact, today as we speak, there are 36 patients from Peoria than our Chicago hospitals.

This is clear evidence that there are significant numbers of residents who would be better

served closer to their homes instead of traveling two hours from Peoria to Chicago Behavioral Hospital or even three hours from Peoria to Waukegan. We are pleased to serve these patients. They should not bear the major burden of having to travel so far to obtain -- and mental health services. Thank you for your time.

MS. CONGER: Good morning. My name is Michelle Conger and I'm the chief strategy officer for OSF HealthCare. In the Peoria area, OSF leadership and clinicians caring for patients have witnessed firsthand the growing need for behavioral health and acute mental illness and patient care.

Over the last several years, more than 600 patients each year who have come to our emergency room seeking help have had to leave the community for inpatient care. As you know, emergency rooms are the destinations where EMS teams bring patients with behavioral health needs. The intense and hectic ED environment is not the ideal location for treating and housing patients until med patients beds can be found.

Over the past three years, OSF -- emergency service providers have made requests to refer more than 1,400 patients from our hospital in Peoria to nearby AMI units at Methodist and Proctor Hospitals which cannot be

accepted due the availability and lack of providers available to treat the complex patients. Our placement teams have had to work hours and even days making phone calls to find available beds for patients. Often resulting in admissions far from Peoria.

In addition to our own experiences, our community health needs assessment has documented the need for more and better behavioral healthcare. The relationship between OSF and US Healthfest began when we realized we had to take action to improve the situation. We were particular with US Healthfest peripherally. And spent a great deal of time learning about their philosophies in determining how a partnership might work.

The support for the project is community based and broad. Over 65 letters from patients, elected state and local officials, community members and others were submitted in support of this project. This includes 15 letters submitted by patients who received inpatient acute mental illness at hospitals distant from the Peoria area.

These letters explain the difficulties in not having local access and the burden of traveling for care. We feel this hospital and behavioral health

services are critical for the Peoria community. Our patients are excited for us to partner with US Healthfest to provide improved and expanded services for those we serve across Central Illinois.

I now introduce Brandon Davidson, CEO of Chicago Behavioral Health.

MR. DAVIDSON: Good morning. I am Brandon Davidson, chief executive officer at Chicago Behavioral Hospital in Des Plaines. CBH opened in 2014 with 125 AMI beds. Following approval from your board in 2014 and -- Maryville Academy to a behavioral hospital. It's now a 147-bed facility operating at over 91% occupancy.

The proposed Meadowview Hospital is committed to serve all patients especially those with social and healthcare disparities. Other products -- excuse me -- other projects before you can make that claim, we can prove it. Based on the current practices in place at the three US Healthfest hospitals in Illinois. These three hospitals provide a significant number of Medicaid service over 60% of the patients at Chicago Behavioral and Lake Behavioral Hospital in Waukegan are on Medicaid.

We serve our communities by offering completely free assessments to anyone needing help. On

occasion, transportation is a barrier to persons needing behavioral healthcare. US Healthfest hospitals contract certified healthcare transportation companies to provide passage to and from treatment.

The partnership with OSF continues these commitments. OSF is now the largest Medicaid provider in Illinois and has numerous outreach programs that have been addressing disparities. The safety net section of the permit application refers to 14 census tracts in Peoria and West Peoria that score among the highest in the United States on a social vulnerability scale developed and used by the CDC.

This index measures such factors as high poverty, unemployment, minority status, crowded households, low percentage of vehicle ownership and disability in measuring local vulnerability.

I now introduce Ralph Webber to respond to the negative findings.

MR. WEBBER: Thank you, Brandon. I'm Ralph Webber, the CON Consultant. Before I address any of the findings. I, again want to thank Mike and George for their technical assistance. We appreciate their time and expertise on all aspects of the regulations and their availability to answer our questions as we prepare

the permanent commitment.

The first thing in the finding is that there is a calculated excess of 41 medical cert -- I'm sorry, acute mental illness beds in -- Peoria HSA2. I have three comments relative to the finding.

First, the calculated excess beds is based on state standard of 11 AMI beds for 100,000 population. Other experts in behavioral health have recommended a range of 40 to 50 beds per hundred thousand. These include a study published by the Pew [ph] Charitable Trust and the assessment by the Treatment Advocacy Counsel. The State has to use the adopted standard of 11 beds. If I -- if I were sitting in Mike's chair, I would have written exactly the same -- finding. You have to -- you have to use that standard. But it is an old standard with the increasing level of mental illness nationally, there is reason to question whether it remains a reliable standard.

Second comment, almost 1,900 adult residents of HSA2 in 2021 left the area for inpatient acute mental illness. I think about 60%, two thirds of them, 66% came up to the three hospitals in Chicago. That's 38% of all residents of the HSA who are hospitalized for mental health. You add the folks who were hospitalized,

but -- and maybe in the area, some not, but in a medical surgical bed, that's where you get the 45% total of residents of the HSA to who could not get an AMI bed in their area.

This fact implies that significantly more beds are needed and the standard is too low. Travelling up to 200 miles for inpatient AMI care doesn't -- because it's more convenient. It is an absolute hardship on patients and families and evidence of a major access problem in the healthcare delivery system in Central Illinois. The three AMI units AMI units in the HSA are not sufficient for the area of 647,000 residents.

Third, the ratio of AMI beds per population from the 21 planned areas in Illinois averages 32 per hundred thousand. HSA2 now has 17 beds per hundred thousand which increases the 23 beds to 44 additions of the adolescent and child psychiatry beds for the Young Minds Institute Project.

That was true last July, but it's not yet under construction. HSA2 is below the average for the state. The average is not a standard, but it is a data point that supports the case for more beds.

As you know, almost any project proposing to establish any new clinical emergency room in Illinois

faces an almost automatic negative due to the calculated excess capacity. The Board has approved most of those projects based on the appropriate merits of the individual cases. We ask that you consider this project on its merits as you did on other projects that were approved even though there was a calculated excess --

The second negative is unnecessary duplication. This criteria is negative when there are existing facilities in the area operating below the occupancy standard of 85%. As shown in Table 3 of the State Board's staff report, there are the three AMI units in HSA2. The large 59-bed AMI unit of Carl Health Methodist Hospital has averaged 85% for the last six years. It is meeting the standard that Meadowview will not be drawing patients from there to cause it to track the lull. So let's put that aside and concentrate on the other two hospitals with AMI units to see what capacity they can offer.

The small 18-bed AMI unit at Proctor Community Hospital and the small 26-bed AMI unit at OSF St. Elizabeth's Medical Center in Ottawa both average 55% occupancy over the past six years. If those two hospital AMI units were at 85%, what would that mean? That would mean an additional average daily census of

only 13 acute mental illness patients at the two hospitals. This equates to an extra potential of 460 AMI patients a maximum for the year that would be accommodated at those two hospitals, but number one, these two hospitals do not offer the specialized AMI services that are needed by many of the patients who travel to Chicago -- for care.

Number two, the potential extra volume of the initial 460 patients is way below the 1,900 adult patients leaving the area for care in 2021, way below the 11,000 patients that Dr. Kresch mentioned residing in the HSA and served by the three US Healthfest hospitals in the Chicago area, and certainly way below the 4,000 plus patients that doctors, counselors, agencies that the area up through HC have committed in writing to refer to Meadowview. None of these volumes could be accommodated in the available bed capacity of the two AMI units in the area. None of the area hospitals have opposed the project which is usually the case if there is unnecessary duplication.

So in conclusion, the limited bed capacity in the area is not adequate to address the excess issues associated with the exodus of patients, adult patients from the area. Based on this, we claim that there is no

unnecessary duplication.

Finally, as stated in the State's staff report, there were 21 total review criteria. Nineteen are possible. There are just these two negative findings. Thank you for your attention. Looking forward to answering your questions.

CHAIRWOMAN SAVAGE: Board meetings have questions, please -- go ahead Mr. Kaatz.

MR. KAATZ: Thank you, Madam Chairman. If I could, and I don't know who to direct this to, but I have a couple questions to start with. My first one is, what do you think is at the route of this increased demand? If, you know, when Ralph mentioned that it was 11 AMI beds per thousand 20 years ago or 30 years ago and now it could be 40 or 50, is it a readmission rate? Is it prevalence? Is it incidence? Is it -- are we doing a better job of diagnosing them? Are there more dual diagnoses? What -- just generally, what do you think is at the route of this tremendous increase in demand?

MR. SEARS: The quick answer to that is literally, yes. All of these things are contributing. And we have great significant increase in need prior to the pandemic. The pandemic generated a whole different

world than we have ever thought about in the --

In the CDC's auto [ph] reports during the pandemic, we were seeing increases of about 30% in a depression. In anxiety and substance use disorders. Now that we're coming out of the pandemic things are opening up again. All that trauma, all that stress is not -- going away.

I actually equate kind of what we've gone through as a world through the pandemic to dealing with the realities of combat veterans. We don't use your combat veterans to suicide when they're out in the theater of war, it was -- there. When they're trying to deal with what has changed in their lives. What's different? You're never going to be quite right again. That's what we're coming out with the pandemic at this point. We are having a whole different world that everyone's told, okay, get back to normal. Go back to work. Go back in public. Get everything back together the way it was before. Nothing is the way it was before. And over that time you'll have less access to physical healthcare. You have less access to mental healthcare. You have all of these stresses, all the substance use and -- and nowhere for it to go. And so we're now dealing with a buildup of extra gap -- from

that time on with all the problems that are -- all been on the surface and the new reality now that's the world we're living in right now.

Having, you know, served at St. Francis Medical Center as the -- psychiatrist for the last ten years now, I can tell you the things that we see come in as a number one trauma center is suicide attempts now. There aren't words to describe what it is now compared to what it used to be. Most of our attempts back even five years ago, people had taken an overdose, you know, generally, one agent. We clean those up. Get them help fairly quickly. Now, if we're lucky, the overdoses are coming in -- I took three different medications, whole bottles of them. Sometimes it's five medications. The amount of self-inflicted attempts by stabbings, shootings, and people are living through them to things that honestly, if I told you some of the attempts people have taken, you probably wouldn't believe me, because of -- almost impossible to believe someone could live through what they did to themselves. And these are the realities of the people that we're having to take care of, get back together well enough to even be able to go get mental healthcare. And everyone that's sitting there wanting or waiting for care is someone that's

taking away resources from all the -- coming in and desperately need that. I am the consult psychiatrist for St. Francis. There's no expert backup plan. We've therapists that help me out and help us, you know, serve our mission, but we desperately need the access to care. We need people getting the care that they need in a place that they can be able to get well so that we can keep moving forward, because otherwise, we have -- the past right now. It is a rough, rough --

MR. KAATZ: Thank you for that answer. Just -- thank you, sincerely. Two quick questions, Madam Chairman. Is this your business model? Military, women, adolescent, adult? I'm trying to recall what -- is this a new business model or subspecialization model in mental health?

MR. KRESCH: Well, it's not new for us. Our hospitals tend to be on the larger size, 100 beds and -- so that we're able to segregate patients in physical spaces that we can provide a treatment program that meets their needs. So a typical hospital setup -- may have an ICU where the most acute patients are admitted and voluntary patients, agitated patients, psychotic patients, the patients who need crisis stabilization on the highest level, they -- and need a treatment -- that

meets those needs to basically settle them down.

We have units that do a dual diagnosis which is very common for patients coming in with psychiatric disorders, depression or -- the most common, but also psychosis and in addition drug use. We often don't know what that drug is, but it becomes part of the treatment of -- any consecutive space.

In our hospitals, we offer all the female patients an opportunity to get treated on a -- which many of our female patients -- history of trauma that is best served by segregating them into women-only units. We have a long and I would say in my own personal career, in my practice as chief, as service to our military vets and active duty, in prior years under contract with local -- we treated 5,000 active duty soldiers with PTSD. And we currently are treating at Waukegan and at Lake Behavioral Hospital. Our recruits basically recruit some activity from the naval station, and typically have 20, 15, 20 patients that they -- just from that one base.

So the elderly adults, geriatric patients need to be treated separately. They don't -- clinical needs, there are physical safety needs. Children, adolescents need to be separated in treatment. So having this space

allows us to provide care in the setting that focuses in on that issue.

MR. KAATZ: Thank you. Last question. How do you compare your outcomes to others?

MR. KRESCH: I was afraid you were going to ask a question like that. The outcome -- we participate in outcome studies.

MR. KAATZ: Okay.

MR. KRESCH: And the results are not -- I would say they're not very reliable. In part, because many of our patients are chronically ill. And they're difficult to track. So they wander around. They appear in one hospital then they go, if they need a readmission, they'll go back somewhere else. And it's difficult to track, so while there are outcome studies, the results are not great. And --

MR. KAATZ: But you participate in them?

MR. KRESCH: We do.

MR. KAATZ: Thank you. Understood.

CHAIRWOMAN SAVAGE: And is the intention for this hospital to have all of those different levels of care for the -- and women in that same model?

MR. KRESCH: Yes and no. In part, we look forward to working with -- they will be providing child

and adolescent. So our focus initially, we'll be focusing on the adult population, and the setup of the hospital will be very similar, segregating patients --

CHAIRWOMAN SAVAGE: Thank you.

MS. MARTELL: Madam Chairwoman.

CHAIRWOMAN SAVAGE: And Dr. Martell.

MS. MARTELL: A couple of questions really related to the charity care policies. One is, we were sent kind of a sample of the Charity Proud [ph] seat in US Healthfest. Is that congruent with OSF HealthCare's charity care policy?

MS. SZE: Yes, it is.

MS. MARTELL: So it mirrors that?

MS. SZE: It's mirrored. Yes.

MS. MARTELL: Okay. Second question is, can you explain the variability in percent to Medicaid revenue from your preexistent healthcare center?

MR. KRESCH: Well, there is some variability from all the house rules and basically, we serve any patient that appears at the hospital in need of treatment without regard to pay a fee. So our statistics are -- naturally occur in the communities that we serve. So the difference between say, Silver Oaks Hospital which has a lower Medicaid base, and CBH

which if you had Medicaid, Medicare and Tricare, over 80% of the patients are -- so and that just simply reflects the community and a -- we don't manage or try to influence that --

CHAIRWOMAN SAVAGE: Hardy-Waller [ph].

MS. WALLER: Thank you. And thank you to each of you for the presentation. It was very thorough. So thank you for that. My comments were actually going to start with Dr. -- she hit it right on the -- on the head. What we know for sure is that mental health is a significant health crisis that we experience not just in Illinois, but across this country and absolutely Covid has truly exacerbated that where we've seen numbers double or triple in terms of who we're treating for mental illness. So that coupled with the fact that 1,900 of residents in your area have had to be transitioned outside, certainly not lost on me that the hospitals really need it in that area.

Where my bigger concern would be and I say that lightly, and that is the joint venture. So we have a joint venture with USS Health, a for profit, and OSF, a nonprofit at 20% of that joint venture which are. And I believe it was brought up earlier in some of the commentary around the assurance that the for-profit

entity really looks at the overall care of the patient while we know that for profits and nonprofits at the end of the day, the business model or the core business model is the patient. For profits oftentimes have a different priority when it comes to the bottom line and the return on investment.

And so I think the question was sharing some assurances and I've heard some of that in your discussion already, but assurances around Medicaid access, the ease to Medicaid access. And I -- I heard you, Mr. Kresch, talk about, you know, each area sort of dictates the number of Medicaid patients that you see. We understand that Peoria has a very large Medicaid population and so understanding that as well as the continued collaboration, I hear you talk about Carl. And OSF already has a very strong reputable reputation in the area.

So just those assurances that US Desk Health will continue to provide that level of care for the underserved and the Medicaid populations.

MR. KRESCH: I think our record speaks for itself. And the history, as I mentioned, the statistics on the Medicaid participation in our patient population is very high. And probably higher than most hospitals

in the state. We, during our process of getting to know OSF and OSF fitting into -- and first started through an actual practical, you know, real life. We have many patients from the Peoria area would refer them to our hospitals in the Chicago area, and we accept them all. We don't ever ask the OSF -- verify this. We never make a decision on admission based on insurance -- so we have never done it. I mean, I've run our business like this for over 20 years. We're still here. Business is financially stable. As a freestanding psychiatric hospital, the reimbursement of Medicaid, Medicare, Tricare is actually suitable for our -- space. The cost of operating the psychiatric hospital and freestanding psychiatric hospital is much lower than a med surge hospital. And the reimbursement that we see -- the fund.

So -- in reality, there's no -- to try and change, influence our payer mix. And at the end of the day, in terms of financial stability, Medicaid, Medicare, managed care, it all comes out about the same.

MS. WALLER: Thank you for that explanation.

UNIDENTIFIED SPEAKER: Madam Chairman.

CHAIRWOMAN SAVAGE: There's another --

MS. WALLER: Sorry.

CHAIRWOMAN SAVAGE: -- comment.

MS. CONGER: I appreciate the question. And you know, OSF did not take this partnership lightly. We've spent a significant amount of time and due diligence. And we're making sure that it was aligned with our values and mission of OSF. Part of the agreements we will have to -- and you know, we -- one of those. We have to speak with clinicians, because we want to make sure that as we build this together that it stays aligned and we also visited their other joint ventures in another hospital to make sure that it made sense, you know, that it did align appropriately. So we feel like we have done that due diligence and have the appropriate assurances and due process swell.

MS. WALLER: Thank you. And that was going to be another question, the Board structure and whether or not obviously, the Board is supportive of the level of care and what the underserved that you provide.
Dr. Sears.

UNIDENTIFIED SPEAKER: And OSF is one of the largest providers of Medicaid services in Illinois. It's a 14 hospital system.

MR. SEARS: And just as boots on the ground, I can tell you it's always been easy to work with them.

They have taken our patients reliably when we call them. If they have a bed to give us, they take our patient regardless of what their payer source is or anything. When I heard that, you know, we were in talks with them, you know, I was very excited because of that reality. They are a reliable, trustworthy partners that take on very difficult cases that honestly, other people don't want to take for us.

CHAIRWOMAN SAVAGE: Thank you. Mr. Fox.

MR. FOX: I've got a short question. I don't mean to prolong the -- the conversations too long. 60% of your patients and two of your hospitals are Medicaid, and I'm presuming that that payer mix in part reflects their lack of access to more -- to primary mental health services. And in result, when they get into -- they get into crisis more quickly than the general population, and end up as inpatients. I would just maybe ask you to validate that view that these folks just simply don't have access to mental health services that the average person living in the community does.

I guess, I'm just trying to understand why you have so much Medicaid when the payer mix is actually so different in many of the markets that you serve.

MR. KRESCH: Well, I apologize for that. My

phone was ringing in my ear. So again, if I understand the question correctly, the -- we don't have control. We don't try to influence our payer mix. So if we are in an area, and our hospital's -- our goal in all of our hospitals and has again, work well for us for a long time. As we just want to be kind of like a cog in the wheel of the world of the healthcare system.

So what we want is when an educated disruptive psychotic patient appears in the med surge hospitals needing at 3:00 a.m. on a Saturday night and they're struggling with all kinds of trauma and illness and this patient is, you know, just sucking up the resources of an ED that -- what that hospital wants is someone to say yes. Not to ask a million questions about -- and see what we can do to try and help. Our answer is yes. And so in that way, we essentially make a friend, and our biggest referral source. And it makes good sense just business wise as far as, and in addition to any community service I can --

So the -- you know, what happens, happens in terms of the payers. I think as -- I'm glad to hear that, and I'd say that Brandon is the chief architect of this that our hospitals are willing to take difficult patients. We're geared up for that. We're staffed for

that. We're trained for that. That's our mission. And so we have, you know, just think about it, we heard some testimony about patients that had to wait extended periods in EDs and be transported hours away from home. Those folks when they get to the psychiatric hospital, they're not in great shape. And they're upset and they're agitated and whatever condition brought them into the hospital is now worse. So we're willing to accept that. We successfully treat patients like that. We have the capabilities and the philosophy of the hospital, each individual hospital is to say yes to difficult patients. So in terms of the -- just from naturally occurring phenomenon.

MR. FOX: Thank you.

CHAIRWOMAN SAVAGE: Anything -- we have -- this is from one of the doctors. Excuse me. You have been running the ER in the past, and that was the biggest problem too, not having a place to send our patients who had mental health needs, and that was a big issue, but I think what Mr. Fox's view was kind of going for is because of the pandemic and all of the lack of services -- virtual services, the fact that in Peoria, are there enough outpatient sort of services to direct them into your hospital, and in their areas from Chicago

where it's so Medicaid-focused, maybe is there more access there for the outpatient to be -- to those hospitals.

MR. SEARS: So that is honestly a giant challenge that we continue trying to solve as OSF. I can tell you just from our Peoria experience, when I signed on with OSF ten years ago, I was supposed to be the sixth psychiatrist in the area. When I got here, I was the fifth. Within a year and a half, I -- there were three of us. At present, there are two full-time and one, one-day-a-week left within OSF Peoria. Otherwise, we have some psychiatric APMs that are trying to help hold things together, but this is ultimately the challenge of psychiatry outside of Chicago in the state of Illinois.

Unfortunately, we know that psychiatry is a coastal specialty in the United States. If you are not out on the east coast or the west coast, you have a dearth of psychiatrists practically a wasteland of, and if it weren't for Chicago, we would probably be ranking nationally in Illinois pretty close to somewhere around the Dakotas in terms of mental health services. Chicago buoys our numbers significantly and still, we trail much of the country even with counting Chicago's boost.

And so we have to fight hard to get people to come and provide the services in our area, and we're competing even within Illinois against Chicago. And so like begets more like. When you're got more psychiatrists you're going to get more psychiatrists. They're not a lot of people signing up for, hey, who wants to come be in rotation, on-call every third day on average? Or the way we run, actually is every third week on average, and so, the reality of my life is I'm often working 12 days in a row, off 2 days, work another 12 days in a row, off 2 days, work another 12 days in a row. And that's just how we survive, and it's how we are able to provide services to folks. We work our butts off. We are trying everyday to recruit folks and I have gotten nine years consistent thanks, we -- we are so happy that you guys are trying to do this, but I'm going to take my services elsewhere and that's the reality of working in a nonprofit in Central Illinois right now.

MR. KRESCH: Just one additional comment. The hospital will have outpatient services. And it has a continuum of services as our others do which would include day hospital treatment with either a partial hospitalization program or intensive outpatient program.

We do med management, medication management for patients who are on long-term medication, but may be treated at other resources in the community that don't have the ability to prescribe medications.

Some of our facilities in the -- as we -- as time goes on whether we can obtain sufficient staff and if the need is there for lower levels of care and in the -- but the patients are not discharged from the hospital and just present out to the extreme. Now, that is a problem -- transported a long distance, because it's not feasible for a patient from this area to follow up in outpatient or even a partial hospitalization program in Des Plaines, they need to be --

MR. SEARS: And I would add how important that reality is. We have a PHP program that serves our patients that are, you know, either diversions from the ED or failing outpatient as regular, however, that service is usually at least a two to three week wait to be able to engage in those services, and that's not even taking into account individuals that are likely to step down from inpatient to that program, because we're essentially not able to even make that a possibility right now, the availability we have.

That is one of the best ways of preventing

recidivism actually, is having those step-down services available and help stabilize people from a -- we all know that, you know, the reality of how long people stay in the hospital now is probably not ideal to really stabilize folks, that's why the step-down programs are so vital to preventing people back in the hospital, but again, we're all just trying the best we can to provide some level of services. And the more that we have, the better it's going to be.

MS. TANKSLEY: I just had a couple of follow-up questions and thank you so much for your time and the presentation. I am going to go back to the charity care question, because I just need some clarity as well.

So the policies are similar. Is there a reason that they're not just -- that you just adopt the -- the OSF policy?

MS. SZE: So we have reviewed the OSF policy and we are comfortable with adopting it.

MS. TANKSLEY: All right. And then the next question that I would have, thank you doctor. I also am in a behavioral health space. And I understand -- I -- I drew the pitcher [ph] and I understand a lot of the challenges. One of the -- you mentioned so much, I have

so many in my -- you mentioned something -- two things that I just want to kind of get a little bit more information or, you know, maybe this is just comment for food for thought for you guys as you go back, you know, but there is a staffing shortage, tremendous staffing shortage throughout this country, definitely in the State. And to open a hospital with 100 beds you're going to need a significant amount of staff to be able to provide that inside. I'd like to know just what your thoughts are in regards to how you're going to get that staffing given the challenges of getting individuals to want to work. I went to Southern Illinois Medical School, so I understand the challenges of having people stay, right, in Central Illinois, so how are you going to do that when we right now have 13 providers for every, you know, 10,000 folks?

MR. KRESCH: So we have had the experience of opening 12 de novo psychiatric hospitals. So we've been through this process before. Some of our prior projects have been in places that are challenging to recruit to. El Paso, Texas is an example. Where there were no psychiatrists, very few people who were trained -- as a smaller organization, we have great flexibility in providing incentives and -- arrangement that is

attractive to people. We -- the hospital also starts and ramps up gradually, so -- patients at the very beginning. We had started with basically one unit open and then as the staff adjusted we were able to -- sufficient people to provide more services -- more and more patients. So it takes a year or so for the hospital really to fully reach its, you know, sort of full capacity, and that does give us time, but the -- we have had a great deal of experience in recruiting people, and you know, we assume that we will be the -- actually begin talking to people already and do a lot of advance preparation as -- personnel. So that is the -- the way may be a little premature.

MS. TANKSLEY: And probably not -- we've got to choose from. I -- I think that's good that you're looking at that though -- maybe look at different models, different ways that you can provide those services and not necessarily have to provide on a short number as not a lot of psychiatrists coming out of med school or things of --

So the next question that I had was kind of also going towards your discharge plan and those types of things. So you hit a little bit on, I think what we were saying as far as, you know, you're going to have

some outpatient facilities and things like that available in that -- in that space, I think. My question was going more towards -- and so maybe you answered it, but it was really going more towards -- would ensure or at least try to work with making sure that patients are going -- not going to fall through those cracks; right. Because you did mention, and we've mentioned on multiple times that -- gap there in the distance. There's a gap in all of these different things, but it doesn't mean there has to be a gap in the -- the care that we provide, because discharge planning, you know, those referral resources to others in the communities that have come from all those things are feasible things that, you know, definitely can be done. And I think we have to kind of think about those things as well, because when we -- when we look at outcomes, you mentioned, you know, we participate in these studies, and the outcomes aren't really all that great. It's not our patients that make our outcomes not that great, because we can't find -- and then things like that often it's the way that we are looking at it, we know that's the way that they -- that they live their lives then maybe we should be a little bit more flexible as well so that we can get to outcomes, you know, as

opposed to an onus on them.

MR. KRESCH: So you raise a very interesting point in that the inpatient stay -- illness bed is really only the start of treatment. Well, I probably shouldn't say this, maybe the primary goal is not to make the patient well, but to engage the patient in treatment, to make the patient aware that there is help that they can do better and there's only so much you can do in an average length of stay of seven or eight days.

So the step-down programs that PHP and IOP really are an extension of the inpatient stay. Beyond that, we first look to community resources, because the needs extend beyond the medical treatment. Maybe housing is the primary need for many of our patients. We don't have a suitable place for them. That's something that's really beyond the scope of what we, our knowledge is. So we when need to do work with community agencies. We can support them. We can't always do what they do, and so our role is at a certain bandwidth, but that bandwidth needs to be extended by collaboration with -- and services, and community. That's really how we see the bigger picture. And we have a sort of small goal [ph].

CHAIRWOMAN SAVAGE: Thank you. Dr. Waller.

MS. WALLER: Thank you. And actually, my question was asked of -- by Dr. Tanksley, but I do want to say that I really applaud your innovative approach to mental health services. Knowing a little bit about mental health, behavioral health, particularly on the post-acute care side, I know that it is critical to be able to -- through patient without patient and be able to have partners in the community who do that work. So thank you Mr. Kresch, for that.

So again, applaud that effort. And I think that is critical and not -- that has been a success --

CHAIRWOMAN SAVAGE: Any other questions by board members or staff? Okay. Don, if you would like to call the roll.

MR. JONES: Mr. Butte.

MR. BUTTE: I approve the project. I know that there is a severe lack of services. I do appreciate all the conversation around access for the Medicaid patients. We need to take care of everybody who suffers from this illness --

MR. JONES: Mr. Fox.

MR. FOX: I want to compliment all the people who drove up north today to -- and testimony. I'm very impressed with the -- of most of the local -- providers

who are supportive of this -- also and I appreciate the partnership that -- as well as the partnership -- with us closer to home here. I appreciated Mr. Webber's comments about beds per hundred thousand and now that relatively lower number is manifested in various outcome -- of patients from the community, and I want to thank the presenters for insightful and comprehensive --

MR. JONES: Mr. Kaatz.

MR. KAATZ: I too would echo what has already been said. I first of all think you guys are a very effective team. You'd never guess you were from two different organizations, a nonprofit and for profit. And I want to thank you for that. I think it was a learning experience for me. You definitely know what you're talking about. We definitely need to hear you come back here and share some of your successes.

I personally feel a little better about an approach to acute mental illness than I did coming in here. Because I think you guys really know what you're talking about. And I really like your approach. Enough said, and I will -- and I wish I could call the question that really summed it, but I can't. I will vote yes.

MR. JONES: Ms. Legrand.

MS. LEGRAND: I will also vote yes. Being

from even further south, not quite as far as my friend here, but I understand how it is for mental illness and getting the providers to come down, I didn't realize that we have -- all of those things back to Chicago, so I'm glad you're doing what you're doing and I vote yes.

MS. MARTELL: I vote yes. Thanks, Don. There's that board report and the comments today in response to our questions. Thank you.

MR. JONES: Ms. Hardy-Waller.

MS. WALLER: Thank you. I did -- all my colleagues' comments and I vote in favor of the project given the testimony that you provided today and the statement board.

MR. JONES: Dr. Tanksley.

MS. TANKSLEY: I vote yes. Echo all of the comments made. But especially because of the adoption of the -- policy of OSF.

MR. JONES: Chairman Savage.

CHAIRWOMAN SAVAGE: And I do vote against based on the State Board's staff report and the testimony today and -- thank you.

MR. JONES: The project has received eight affirmative votes.

CHAIRWOMAN SAVAGE: Okay. So in accordance

with § 45 of Part F, the affirmative vote of eight of the members of the State Board shall be for six of the members of the State Board shall be necessary for any action requiring the vote to be taken by the State Board. This project is -- votes to approve. According to the rule -- officially approves the application. All information received during this review process -- all other testimony and the applicants -- presentation and its approval. Please know your permit is effective today and you will be receiving a permit letter outlining the confines of the project as well as all post-permit requirements. Thank you.

MULTIPLE SPEAKERS: Thank you very much.

CHAIRWOMAN SAVAGE: Now we will take a short ten-minute break.

(Off the record.)

(On the record.)

CHAIRWOMAN SAVAGE: We will come back into order. Thank you, everyone. Now, we are going to -- University of Chicago Medical Center. So may I have a motion to -- permit renewal of Project 16-008. It is the second permit renewal request for this project.

UNIDENTIFIED SPEAKER: I so move.

BOARD MEMBER: Second.

CHAIRWOMAN SAVAGE: All right. So if three can introduce yourselves, spell your names --

MR. OURTH: Joe Ourth, J-O-E, O-U-R-T-H.

MS. CHASE: Emily Chase, E-M-I-L-Y, C-H-A-S-E.

MR. JOHNSON: Judd Johnson, J-U-D-D, J-O-H-N-S-O-N.

Whereupon,

JOE OURTH, EMILY CHASE, JUDD JOHNSON,

being first duly sworn or affirmed to testify to the truth, the whole truth, and nothing but the truth, were examined and testified as follows.

THE COURT REPORTER: Okay. You can lower your hand.

MR. JONES: Thank you.

CHAIRWOMAN SAVAGE: Okay. George -- State Board Staff Report.

MR. ROATE: Thank you, Madam Chair. In May of 2016, the State Board approved Project 16008 which authorized a major modernization project on the campus University of Chicago and Medical Center Bernard Mitchell Hospital of Chicago. The State agency notes the project is obligated and the current project completion date is March 31st. The project cost $120,444,000.

The project has -- has gone through two permit alterations. One in reduction, one in increase. A previous permit renewal bringing it up to the date of March 31st. The current permit renewal request is requesting a nine-month extension from March 31st to December 31, 2023.

CHAIRWOMAN SAVAGE: Thank you. And who would like to proceed.

MR. OURTH: Good morning, Madam Chair and members of the Board. I'm Joe Ourth, CON Counsel, and I had an opportunity to represent the University of Chicago Medical Center. And I'm pleased to have with me today, Emily Chase. Emily is the senior vice president for patient services and the chief nursing officer for UCMC. And Judd Johnson who is the vice president of planning design and construction.

As George said, this project is related to a project that the Board had approved several years ago which was really a project that had two components. As many of you know, the chief component of that was the emergency department expansion and creation of the first level one trauma center on the south side for many years.

The project also included as part of a

renovation of the Mitchell Hospital building. Then two years ago, I came before you and downsized that Mitchell renovation in the anticipation of filing a master design permit for the creation of a new cancer hospital which you had approved and which next month you will be seeing the full project on that. So we'll see you back there then.

And last year we came before you with a minor alteration to just add one CT Scanner to that. As you see this is a fairly big project. Normally that wouldn't even require a CON, but because it was in the space, it had been part of that modernization, we felt we needed to come back and so there was the addition of that CT Scanner.

The other two major components of the project, the trauma center ED is long completed. The Mitchell renovation is completed. So the only thing left is the renewal for the completion of the CT Scanner. And Emily can explain the -- that and what's going on with the emergency department as well.

MS. CHASE: Thanks Joe. Good morning. Emily Chase. Joe called it a small upgrade with adding a CT Scanner, but clinically, it actually is a large upgrade for us in the emergency department. So our adult

emergency department opened in 2018. It became the busiest in the state by 2020. We just passed our five-year anniversary of being a level one trauma center. And we've officially surpassed serving 19,000 patients as part of our trauma center in those five years.

We continue to also be a comprehensive stroke center. So that CT Scanner that we have in the emergency department is operated almost continuously 24/7, 365 days a year. It's five times over the recommended utilization rate of a CT Scanner by the state of Illinois. And so we saw the need to add this second scanner.

As Joe mentioned, we are substantially completed with the construction piece. We're waiting on the scanner to be delivered. Which we are hoping will happen in early fall. And I can tell you that it will decrease our wait times for our CTs dramatically, just with a backup of patients consistently waiting for that single scanner. So we're happy to take other questions and Judd is leading our construction efforts as well.

CHAIRWOMAN SAVAGE: Do our board members have any questions for --

Mr. Kaatz.

MR. KAATZ: Madam Chairman, thank you. 19,000 trauma --

MS. CHASE: Correct.

MR. KAATZ: -- patients?

MS. CHASE: Correct.

MR. KAATZ: Only?

MS. CHASE: Just trauma -- patients.

MR. KAATZ: Only from the trauma program?

MS. CHASE: Yes.

MR. KAATZ: And how many ER visits in total per year?

MS. CHASE: We see about 82,000.

MR. KAATZ: And do you separate pediatrics from adults?

MS. CHASE: We do. This is just for the adult trauma center and the adult emergency department.

MR. KAATZ: So when you say 82,000, that's just adults?

MS. CHASE: That's correct.

MR. KAATZ: And do you do pediatric trauma also?

MS. CHASE: Yes, we do.

MR. KAATZ: And now you're going to have -- you're going to have two CT Scanners in the ER?

MS. CHASE: Correct. Yes, in the adult emergency department. You know, we really want to make sure that we're meeting those standards for quick turnaround times on our CTs. For a level one trauma as well as our comprehensive stroke center patients. And so, you know, we've seen those wait times increase with the overutilization of the scanner, and really felt the need to make sure that we could go forward with this second scanner.

MR. KAATZ: What's the size of the magnet you're going to get?

MS. CHASE: I, you know what, I don't even know. Do you know?

MR. KAATZ: Never mind.

MS. CHASE: My facility is going --

MR. KAATZ: Is this the -- is this becoming the standard for ERs, emergency departments to have CT Scanners in them?

MS. CHASE: You know, I would say for this level of trauma and -- that we're seeing, that immediate -- now, we have other CT Scanners across our campus, obviously.

MR. KAATZ: Yeah.

MS. CHASE: But the immediacy of having this

in the emergency department, being able to treat immediately based on that CT Scan, we basically have the trauma patients in there in under 30 seconds from being in the bay. That's a game changer for these patients.

MR. KAATZ: Within 30 seconds?

MS. CHASE: Once we stabilize, we were right into the CT Scanner.

MR. KAATZ: Wow.

MS. CHASE: The CT Scanner actually opens into the trauma bay, so it's a really nice setup for hour patients.

MR. KAATZ: Thank you.

CHAIRWOMAN SAVAGE: Ms. Waller.

MS. WALLER: Thank you Madam Chair. Hi Emily. Question, and can you share a little bit about -- because I would imagine this would've a significant impact on utilization, particularly given that your utilization rate is higher than the entire state. The demographics of the community that you serve, particularly around stroke, I would imagine a community has a higher incidence. Can you talk to us about that a little bit?

MS. CHASE: So I actually can tell you, I do know this statistic off the top of my head. So over 60%

of the patients that we serve in our comprehensive stroke center are from our 12 Zip code area, around our hospitals. So I mean, these are -- this is our community; right. Now, we do obviously as a comprehensive stroke center take in patients from other hospitals, across the area, but that 12 Zip code radius around us, 60% of our patients for our comprehensive stroke center.

So you're absolutely right. I mean, this is directly serving our community and it's something that we're really proud of and want to be able to continue providing that immediate access to care for our stroke patients.

MS. WALLER: Great. Thank you for that. I live down the street, so I know exactly where you're talking about.

MS. CHASE: Okay.

CHAIRWOMAN SAVAGE: Other questions? Mr. Kaatz.

MR. KAATZ: So I remember when the trauma center opened five years ago, it was a very big publicity -- a lot of publicity, political et cetera, et cetera. In retrospect, pretty good decision?

MS. CHASE: I mean, I would say it's one of

the best decisions we've made in my tenure.

MR. KAATZ: Okay.

MS. CHASE: I've been at the university for 13 years. I would say it's a program that we are extremely proud of. And if our trauma surgeons were here, they would say the same. I mean, we're providing immediate access. I also have this similar statistic that over 50% of our trauma patients are from our 12 Zip code radius. So, I mean, this is our community; right. And again, we're taking in patients going, you know, it's a bigger radius than that, but that 12 Zip codes, 50% of our trauma patients -- from our neighborhood.

MR. KAATZ: So the -- the community input was incredibly valuable on this one.

MS. CHASE: Absolutely. And we still have our community advisory board. We meet with them every quarter at minimum. And they're providing feedback to us on an ongoing basis. So that wasn't just an exercise from five years ago. I mean, that's a continued exercise for us.

MR. KAATZ: Wow.

MS. WALLER: Yeah. I think the other significance of that is the fact that not only are you treating your community, your demographic, when you look

at your pair source mix in that area, you're going to have a significantly high Medicaid in over-served populations as well.

MS. CHASE: Absolutely. That's right. And you know, we've added a lot of trauma wraparound resources is what I would call them, you know, social workers and those that can really help these trauma patients get back on their feet, back in the community, and I think that's also something that we're really proud of. It's not just this urgent care, right, which is of critically lifesaving importance, but that it's getting these patients back into the community and preventing future trauma.

MS. WALLER: Right. Thank you.

MS. TANKSLEY: I just had a quick question about what the Bernard Mitchell upgrade, what is that like what's the -- the thought or the plan behind that? I was not on the Board when that was --

MS. CHASE: Yeah. We're happy to --

MR. JOHNSON: So there was an initial proposal for a significant upgrade, major reconstruction to a mental hospital which was originally built in 1983. And their planning was done around that. Again, as we've indicated here, we've revised those plans significantly,

and but within the Mitchell building itself, there were upgrades to infrastructure system that support the facility, HVAC, heating, hot water, plumbing, those types of upgrades made, but then also on the patient units themselves, they were refurbished, physically refurbished and renovated, but then also significant up greats to the IT system that support the patient units, and all of the now integrated IT systems, patient care system that support, you know, day-to-day care in those units.

MR. OURTH: And Doctor, just to follow up a little bit for me. The original plan was that the renovation of Mitchell could serve as the cancer hospital that you've heard us talk about. And Judd can get into a lot more detail about that, but going into an old building on that discovery that could not be retrofit in the way to provide the standard of care that they wanted to provide. And so that's the reason the project was downsized, made kind of a lot of money out of it so that that could be used for the now cancer hospital that you'll hear about next.

CHAIRWOMAN SAVAGE: And I have a question. And are you saying that -- because I know Allegra Delivery [ph] -- agency there, a long time ago. And

thankfully, I'm glad you renovated. But are we going to be on -- when that building with the cancer center?

MS. CHASE: So we actually moved the labor and delivery over to the Comer Children's Hospital. It's a beautiful unit, you can come and visit sometime. We would love to show it to you and it's great, because it's in adjacency to the operating rooms in Comer as well as the NICU. Now in the Bernard Mitchell building is our postpartum unit, our mother/baby unit. And that got a full renovation. It's beautiful. The rooms are fully retrofitted. They have the same call systems so they can call back and forth into labor and delivery with this new IT upgrade. So it's been a huge turn around as far as getting those units up to speed.

CHAIRWOMAN SAVAGE: And -- NICU.

MS. CHASE: Right across the bridge.

CHAIRWOMAN SAVAGE: Okay. Those are my questions. Other questions? -- vote.

MR. JONES: Mr. Budde.

MR. BUDDE: I vote yes.

MR. JONES: Mr. Fox.

MR. FOX: I vote yes.

MR. JONES: Mr. Kaatz.

MR. KAATZ: I vote yes.

MR. JONES: Ms. Legrand.

MS. LEGRAND: I also vote yes.

MR. JONES: Dr. Martell.

MS. MARTELL: I vote yes.

MR. JONES: Ms. Hardy-Waller.

MS. WALLER: I vote yes.

MR. JONES: Dr. Tanksley.

MS. TANKSLEY: I vote yes.

MR. JONES: Chairman Savage.

CHAIRWOMAN SAVAGE: I vote yes based on today's testimony and the State Board's staff report.

MR. JONES: We have eight affirming votes.

CHAIRWOMAN SAVAGE: Thank you. So in accordance with § 4I of our act, the affirmative vote of six board members of the State Board shall be necessary for action requiring the vote to be taken by the State Board. Those projects received eight votes to approve. According to the rule of law, the Board consideration of the application, all information received during the review process and staff report offered the testimony, and we have the -- board presentation in its approval. Please know your permit is effective today, but you will be receiving a permit letter outlining the confines of the project as well as all post-permit requirements.

MS. CHASE: Thank you all so much.

MR. KAATZ: And don't come back for a third CT.

CHAIRWOMAN SAVAGE: Now we're going to move onto Project H-04, Project 23-014 Exception Care & Training Center. May I have a motion? I'm sorry, one moment. One moment, change of plans.

Okay. So now we're going to move instead onto Project H-01, Project 22-047, Northwestern Medicine Lake Forest Hospital. May I have a motion to approve project 22-047, Northwestern Medicine Lake Forest Hospital.

MR. KAATZ: So moved.

BOARD MEMBER: Second.

CHAIRWOMAN SAVAGE: All right. And our folks for Northwestern here, so we will take a seat and start introducing yourselves and spell your name for the court reporter and then she will swear you in.

MS. ORTH: Bridget Orth, O-R-T-H.

MS. OBERRIEDER: Marsha Oberrieder, O-B-E-R-R-I-E-D-E-R.

MR. MALIK: Sanjeev Malik, S-A-N-J-E-E-V M-A-L-I-K.

MS. STROM: Christine Strom, S-T-R-O-M.

MS. HALL: Ann Hall, A-N-N, H-A-L-L.

THE COURT REPORTER: Can you all raise your right hand?

Whereupon,

Bridget Orth, Marsha Oberrieder, Sanjeev Malik, Christine Strom, Ann Hall,

being first duly sworn or affirmed to testify to the truth, the whole truth, and nothing but the truth, were examined and testified as follows.

CHAIRWOMAN SAVAGE: George, if you could give us our State Board staff report, please.

MR. JONES: Thank you, Madam Chair. The applicants are proposing a 96 bed addition for Lake Forest Hospital in Lake Forest. The total cost of the project is approximately 389 million dollars.

The applicants are asking the State to approve the addition of 84 medical surgical beds, 12 intensive care beds. This would -- this would increase the bed count to be a total of 168 medical surgical beds, 24 intensive care beds, and 18 obstetric beds for a total of 210 inpatient beds. The anticipated project completion date is April 30, 2028 and there are no negative findings.

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

MS. OBERRIEDER: Good morning, I'm Marsha Oberrieder, president of Northwestern Medicine Lake Forest Hospital. I'm proud to say that I worked at Lake Forest Hospital for 43 years as of last Friday, May 5th.

I started my hospital career in the finance and HR areas of the hospital and then moved into hospital operations in 1999. I've been privileged to participate in the hospital's growth and expansion of services to the many communities we serve for over four decades.

With me today is Bridget Orth, our director of regulatory planning, Dr. Sanjeev Malik, chief of emergency medicine, Ann Hall, vice president of community affairs, and Christine Strom, director of design and construction. We're excited to be here before you today with our proposed expansion project at Lake Forest Hospital.

Northwestern Medicine proudly opened the new Lake Forest Hospital in March of 2018. Which now includes 114 inpatient rooms, 32 observation rooms, 8 operating rooms and 40 outpatient care spaces on our 160 acre campus.

The hospital staff includes more than 700 physicians, board certified and 69 medical specialties

serving patients in Lake Forest and at our Northwestern Medicine -- like outpatient center which also includes a freestanding emergency department.

Since the opening of our replacement hospital in March of 2018, we've been experiencing extreme ly high occupancy. In the six months prior to the Covid pandemic the average combined medical surgical ICU and observation occupancy was 107%.

During the pandemic, we added observation beds and utilizing the flexibility provided by the Covid-19 emergency waivers, we converted 48 inpatient rooms to double occupancy and several pre-post procedure care spaces to temporary holding beds for boarders.

Following these additions, the average occupancy decreased marginally to 100%. One of the reasons for this significant growth at Lake Forest Hospital is the increased access to specialty care. Since our affiliation with Northwestern Medicine in 2010, Lake Forest Hospital has continued to build advanced care capabilities in areas such as heart and vascular, orthopedics, endocrinology, interventional GI, pulmonology, and oncology.

Many subspecialists from Northwestern Memorial Hospital in downtown Chicago also practice at Lake

Forest Hospital which increases access for the residents of the Lake Forest Hospital service area. With the ability to provide higher acuity care closer to them, Lake Forest Hospital has treated more complex cases that previously would've been transferred downtown to Northwestern Memorial. Accordingly, Lake Forest Hospital's CMI has increased from 1.7 in fiscal year 2016 to 2.0 in fiscal year '21, which is a 17.6% increase.

Another contributor of growth at Lake Forest Hospital has been the closure of the Vista West Hospital Emergency Department, just months before we opened the new Lake Forest Hospital in March of 2018. At Lake Forest Hospital, 84% of our inpatient admissions are unscheduled admissions. Through the emergency departments at both the hospital and our freestanding emergency center in Greys Lake.

Scheduled procedures represent only about 16% of our admissions. A look at the rest of Region 10's most recent comparative data reveals the magnitude of the challenge Lake Forest Hospital faces. We have more than twice as many emergency department and trauma visits per licensed bed, and one and a half times more emergency department admissions per licensed bed than

any other hospital in the region.

Patient preference to receive care at Lake Forest Hospital is also a major factor influencing our high occupancy. Hospital data shows that over 40% of the hospital's emergency department patients live outside of Lake Forest Hospital's local communities for more than ten miles from the hospital, indicating that many patients are passing another hospital on their way to Lake Forest Hospital.

A significant portion of the increase in our volume is attributable to growth of patients originating from underresourced communities, particularly Waukegan, Round Lake and North Chicago. Since opening the new hospital, total patient days have increased by nearly 50% while the patient days from these underresourced Zip codes have increased 85%.

In 2020, Lake Forest Hospital provided more charity care than any other Lake County Hospital by a wide margin. Our charity care is a percentage of net patient revenue was double that of any other Lake County hospital. Additionally, the rate of increase for patients on Medicaid is the highest in the county. While the total number of inpatients served at Lake Forest Hospital increased 43% from calendar year 2015

through calendar year 2021, the number of Medicaid inpatients has increased 186% and charity care inpatients 199%.

In short, the volume growth at Lake Forest Hospital reflects the unmet needs of the community and our ability to provide higher complexity of care closer to home. One of the lessons learned from the Covid pandemic is that lower occupancy is essential to having the ability to manage unexpected surges.

Our proposed addition of medical surgical ICU and observation beds as well as emergency department stations and diagnostic imaging equipment will allow Lake Forest Hospital to return to more manageable occupancy at utilization levels.

As stated in the State staff report, our project meets all of the State's review criteria, but we're happy to answer any questions you may have. Thank you.

CHAIRWOMAN SAVAGE: Thank you. Board members, do we have any questions?

MR. KAATZ: Can you tell me what your payer mix is?

MS. OBERRIEDER: Sure. Government payers are about 62%. Overall, Medicaid is right around 15%, and

Medicare is overall about 42%. Charity care is right around 3%.

CHAIRWOMAN SAVAGE: Mr. Kaatz.

MR. KAATZ: If I read it right, your critical care beds -- and I'm talking about adult med surge are about 25% of your compliment?

MS. OBERRIEDER: Our medical surgical beds?

MR. KAATZ: Yeah.

MS. OBERRIEDER: Of the 114 licensed beds, 84 are medical surgical, 12 currently are ICU.

MR. KAATZ: Right. And you're adding 12.

MS. OBERRIEDER: And 18 are obstetrics. So of the 114 are medical surgical.

MR. KAATZ: Okay. And then -- but the percentage then of ICU would be what? 20 -- 25%?

MS. OBERRIEDER: 12 -- less than that actually.

MR. KAATZ: Okay.

MS. OBERRIEDER: 12 of 114, so closer to maybe 10 to 15.

MR. KAATZ: Okay. I thought it was -- okay. Not -- 12. And you are building a new pavilion?

MS. OBERRIEDER: We're building two new pavilions.

MR. KAATZ: Two.

MS. OBERRIEDER: Our --

MR. KAATZ: Okay.

MS. OBERRIEDER: In our community there's a height restriction of 85 feet, so we're more vertical -- I'm sorry, horizontal than vertical. So we have currently three hospital pavilions with 114 beds.

MR. KAATZ: And you're adding two?

MS. OBERRIEDER: And we're adding two more hospital --

MR. KAATZ: And how high are you allowed to go in Lake Forest?

MS. OBERRIEDER: 85 feet.

MR. KAATZ: Oh, 85 feet. Wow.

MS. OBERRIEDER: Yeah. That's all.

MR. KAATZ: Okay.

MS. OBERRIEDER: That's why we are so horizontal.

MR. KAATZ: Thank you.

CHAIRWOMAN SAVAGE: Ms. Waller.

MS. WALLER: Thank you for your presentation. That was -- that was very thorough. Just a question for clarity. So I thought I understood you to say that a lot of the transition or the increase in the admissions

and patient population is coming from the out areas, Waukegan, Round Lake and that there's been a significant increase in Medicaid and charity care from those populations. Did I hear that correctly?

MS. OBERRIEDER: That's right.

MS. WALLER: So with that said, you said that your current payer mix is 15% Medicaid? I didn't hear about your charity. How does that translate? And will that remain the same even after the new hospital is constructed?

MS. OBERRIEDER: Both Medicaid and charity care has continued to increase in recent years. And I only see that continuing, as we continue to add beds. I think we probably are going up 1 to 2% in charity care almost every year.

MS. WALLER: So can you tell me a little bit about the accessibility for those more lower -- lower level pay er mixes to the hospital, understanding that, you know, obviously, you have to meet your bottom line, but that's a significant increase of 199%, that's significant. How do you plan to manage that population coming to your hospital?

MS. OBERRIEDER: We've been managing it in many ways currently. Many of these patients do not have

primary care providers. So one of the important things that we've done is a few years ago opened up a transitional care clinic where hopefully then we can keep the patients out of the hospital for readmissions and things. Really working with those patients with a primary care provider, social worker, and really a medical health advocate that's helping get them into resources, finding a permanent medical home for them whether at one of the HQHCs in the county, we work very closely with the Aria [ph] Health FQHC in Waukegan and the Lake County Health Department also has several FQHCs scattered through the county.

So really working over several months generally. Sometimes these patients are very complex and it takes up to six months or more to really get them all the right resources that they need. I think that's one of the biggest ways that we're doing that.

MS. WALLER: Thank you.

MS. TANKSLEY: I just had a couple questions. One of the testimonies that we received in -- in someone in opposition of this is from one of the unions, and I wanted to hear your response to their concern regarding the necessity for the -- this large dollar, you know -- buildings that you're -- the buildings that you are

creating, just kind of what your response to their concern is, and that concern being the necessity of this --

MS. HALL: Sure. I'm going to take that one. So I think as this project highlights as Marsha shared, this a project that is expected to expand access for people all over Lake County. In addition to this project --

MR. FOX: Could you pull the microphone.

MS. HALL: Oh, sure. Better. Okay. So in addition, what I was saying was that this project is really focused on expanding the access communities across Lake County and the northern part of Illinois. We also as a health system have a number of other projects that are active. Just at your last meeting, you approved through Chairperson Savage a major project that we're doing on the south side of Chicago in the Brownsville community. And so those two projects along with others that we have planned are all about expanding access which is a huge part of our initiatives around health equity. That's sort of the primary component of it as well as activities that are focused on meeting the needs of our employees as well as our community members.

MS. TANKSLEY: I think one of the specific

things that they mentioned was the 400 million dollar investment in Lake County versus the like hundred and something million dollar investment in that south side center that you're planning to build. Could you comment on that?

MS. HALL: So I'll note just the difference of the project. So the project in Lake Forest is an inpatient facility. So inherently, that is much more expensive. The project that we're doing in Brownsville is an advanced outpatient center, so it is a very, very large comprehensive outpatient center. And the reason we chose to do an outpatient center there versus an inpatient unit was really focused on community feedback that we received around very thorough data analysis, inclusion of our community health needs assessment, and discussions with community residents and officials around what would be most needed in that community.

MS. TANKSLEY: Okay. And then just a -- another question, you mentioned that a significant amount of -- of the reason that you're seeing more individuals is because of the -- the closure of the -- I don't want to mess up that name, Vista --

MS. HALL: Vista West.

MS. TANKSLEY: West.

MS. HALL: Right.

MS. TANKSLEY: And I just did a, you know, pretty cursory, I'm not familiar with that hospital, but it seems like it's more of a psychiatric hospital.

MS. OBERRIEDER: It's actually Lake Health -- Lake Behavioral Health Hospital today which was in your presentation earlier.

MS. TANKSLEY: Oh, okay. So that being said, what are you guys doing to actually address the needs of those patients? Like how are you -- if you're absorbing a number of what I would imagine would be psychiatric diagnoses coming in like are you doing anything other than primary care for that? Like are you expanding your psychiatric services or anything?

MS. HALL: So we, in Lake County, we have a very comprehensive partnership with an organization called the Jocelyn Center. The Jocelyn Center is based originally in Waukegan, but expanding quite rapidly. And through that partnership, we are able to get pretty incredible results in terms of access to care for patients who come to the emergency room, the inpatient units or our NMG Clinics. If they indicate a need for behavioral health services then we have a shared resource with the Jocelyn Center who helps connect them

to those services. I think it's 80% of the time they're offered an appointment within four days, and 100% of the time they're offered an appointment within a week. Which is just incredible access compared to what we are able to deliver.

MR. KNIERY: If I may, this OS [ph] was an acute care provider and you're not a behavioral health that came before the Board and converted themselves into a behavioral health with an expansion leaving this east still in the area and you're saying even though they're there, you're still getting these deflections?

MS. HALL: Absolutely.

CHAIRWOMAN SAVAGE: Dr. Martell.

MS. MARTELL: Just a follow-up question. You talked about transitional care. So what -- do you have contracts in place with your federally qualified health centers in Lake County to provide follow-up care and your -- from that, what is your plan for that?

MS. OBERRIEDER: We don't have contracts, but we work very closely with the Aria Health facility in terms of getting patients into their clinic. We actually through our family medicine residency program, our residents also spend 50% of their clinical rotation time at the Aria Health clinic. So between those

working relationships and we also see many of the patients through many of our own internal medicine and family medicine clinics within our own Northwestern Medical Group. The County Health Department, we work closely with them particularly if they're Round Lake, FQHC and they also have some FQHC facilities in the Waukegan general area.

So there's no contracts, per se. We just have great working relationships.

MS. HALL: We do have care coordination agreements in place with both of those organizations.

MS. OBERRIEDER: Right.

MS. HALL: Yes.

MS. OBERRIEDER: They are a coordination agreement, not a physical contract though guaranteeing care.

BOARD MEMBER: All right. Thank you.

CHAIRWOMAN SAVAGE: Mr. Fox.

MR. FOX: Okay. Thank you. We're impressed with the -- most of the subspecialty patient care, more of it in providing -- I think you've partially answered the question that I -- that I came to this -- about fostering this project. It's about 4 million dollars of --

CHAIRWOMAN SAVAGE: Mr. Fox, I'm sorry, could you get a little closer to the microphone?

MR. FOX: Offhand, about four million dollars of that -- but you partially explained in that with the height restriction you have to build separate -- I imagine this could've been built on some of those facilities that would've been a less costly --

MS. OBERRIEDER: Yes, do you want to take that Christine?

MS. STROM: Sure. Thank you very much. Regarding the cost of the facility, had we built vertically versus horizontally, would that cost have been cheaper, that's the question I'm hearing overall. Perhaps overall, but we still would've been completing a very similar scope and scale of the construction overall in that regard as we add onto the building structure and services overall. So it is a challenge to say overall on this -- environment in particular.

MS. ORTH: But we are very pleased to have been within the State's -- for construction from all other construction costs.

CHAIRWOMAN SAVAGE: Mr. Budee.

MR. BUDDE: I probably heard something wrong, but I want to try to understand that you were talking

earlier about during Covid that you dealt with, you know, expanded semiprivate for private -- in my previous life -- southern Illinois -- the same thing. When I look at the Statistics Chart Table 6 though that the bed count doesn't change from the 84. And the occupancy percentage goes up to 190, 721, 147 -- why didn't the number of beds get changed on this statistical chart if in fact you increased your beds during that time period.

MS. ORTH: So we increased our beds temporarily so then 84 is whatever we're technically authorized for. So that's what we kept as of two days from now, we'll be returning to that number. So we did add temporary beds, but the chart just reflects our actual authorization.

MR. BUDDE: Okay. Then in the same chart, projected utilization, you know, you're getting into 2025 and 2024 through 2025 where you're 129%, 144% under -- you're not proposing that while this is being built you're going to be running your hospital at 152%?

MS. ORTH: No. So obviously, the growth will have to slow a little bit over the years while we're waiting for the beds, but that's just showing that's sort of an average --

MR. BUDDE: So that is not for -- this is the

number of patients -- if the growth rate goes as assumed?

MS. ORTH: If the growth rate continues at the conservative rate that we actually listed in our protections, we will have some very challenging years between now and when the beds open. We're going to have to continue to find flexible -- to accommodate that so that -- because again, we have such a high admission rate from the ED almost twice as what we have from the downtown hospital, so a lot of it is outside of our control even if we cancel all of the scheduled cases, it wouldn't help that much with our -- with our effort to census. So we -- it will be a challenge in the next few years until the beds are --

MR. BUDDE: -- diversion.

MS. ORTH: Our emergency room doctor.

MR. MALIK: Hi. Sanjeev Malik, chief of emergency medicine. I'm just going to paint a little picture of the emergency department. So the answer to the diversion question is no. So we partner closely with our colleagues in Lake County. We want to do what's best for the community. And so Condell and all the other area hospitals are in similar capacity challenges. And emergency departments across the

country are struggling with this epidemic of overcrowding. And boarding is incredibly dangerous to the quality of care of patients. So we have kind of partnered, and we don't intend to go into diversion unless it's good for the public.

That said, we are oftentimes left with very, very little choice, and we really have not gone on diversion at all in the last few years, and in Lake County we've kind of partnered together. That said, our emergency department will give you a snapshot, you know, 83% -- 84% of the admissions going into the hospital are coming through the ED, so these are safety net patients coming into the community and these patients are already here. They're just lining my emergency department rooms and can't get upstairs which prevents me from providing the high quality care that we want to provide to the next patient walking in the door.

So the capacity challenges are very, very real, and have significant impacts kind of going forward. And despite having dealt with some of those capacities -- feeling like we're at capacity already, we've continued to grow 8%, ED volume year over year over the last four years despite being at these occupancy levels that you've seen.

And so I honestly do not see that growth slowing down that much for emergency department services, because that's what the community needs. We are -- whether it's psychiatric care that we heard about earlier this morning or whether it's other unmet needs, the emergency department is a safety valve for the community.

MR. BUDDE: How do you care for 128 patients --

MR. MALIK: Very creatively.

CHAIRWOMAN SAVAGE: [Inaudible].

MR. MALIK: Yeah. So we've had to use alternative care spaces in whatever way we can.

CHAIRWOMAN SAVAGE: Mr. Kaatz.

MR. KAATZ: Did I hear you correctly that 84% of your ER visits are hospitalized?

MR. MALIK: No. Apologies. 84% of the hospitalized patients originated from the emergency department --

MR. KAATZ: So 84% of the hospital's admissions come from the ED?

MR. MALIK: Correct. The admission rate is closer to 28%.

MR. KAATZ: 28%. Thank you. And what's the

size of your ED?

MR. MALIK: Currently, we have a 16-bed emergency department.

MR. KAATZ: And is it going to stay -- I can't remember, is it in this --

MS. OBERRIEDER: It's going to 24.

MR. KAATZ: Twenty-four. Thank you.

MS. OBERRIEDER: A 50% increase.

MR. KAATZ: Okay. How many --

MR. BUDDE: Yeah, do physician offices directly -- or does it have to go through the emergency room that influences that percentage --

MR. MALIK: They can direct admit. It's oftentimes difficult to, because of the capacity challenges, but the capability exists.

CHAIRWOMAN SAVAGE: And just for the amount of patients that you have, I see that your completion date is in 2028. Is there a thought that you could be set up in some way to meet the community need?

MS. STROM: So the overall completion date for the hospital is in 2028. We are intending to execute a phased occupancy plan through our construction efforts. This will be a -- review with IDPH overall, but our intention would be to open our beds and emergency

department earlier than that date of the overall project completion. We're very focused on recognizing the need.

CHAIRWOMAN SAVAGE: Other questions? Okay. Hearing none, Don, if you would call the roll.

MR. JONES: Mr. Budee.

MR. BUDDE: This is difficult given the cost of the project and a good friend of mine -- 100 years ago --

UNIDENTIFIED SPEAKER: A no --

MR. BUDDE: Okay. I'll vote yes -- and I just worry about it. I know there's some kind of -- you know, money is finite. And we're spending this amount of money here -- just kudos to have -- I guess the financial resources to do that, but I am --

MR. JONES: Mr. Fox.

MR. FOX: I vote yes based on the staff report including being in conformance with -- 1110 and 1120, and also based on the testimony --

MR. JONES: Mr. Kaatz.

MR. KAATZ: Well, I have a major concern about 4 million dollars of that, but I also know the value of the staff report and the fact that you've met all the criteria. So I will vote yes.

MR. JONES: Ms. Legrand.

MS. LEGRAND: I also vote yes, based on the staff report -- today.

MR. JONES: Dr. Martell.

MS. MARTELL: I'm going to vote yes, but I too am going to express concerns about the high cost, and need to establish more aggressive transitional -- that region, I am concerned about putting our money and our investments in hospitals. Our goal really should be to keep people out of hospitals and not need additional beds. They need specialty care, the FQHCs do what we have -- do not have capacity -- and so we need to expand primary care similar to what our -- in Brownsville, I think would be something that we should be looking at for future -- as well.

MR. JONES: Ms. Hardy-Waller.

MS. WALLER: I vote yes, based on testimony and the staff report.

MR. JONES: Dr. Tanksley.

MS. TANKSLEY: I vote no. I -- the staff report and you did complete the -- you know, all of that is -- is in line, but I will say, I think this is an exorbitant amount of money to be spending on inpatient services. I understand that they cost more. I agree that the way healthcare is going should -- is -- is a

much more focused outpatient, much more day type of -- of procedure. I --

MR. JONES: Madam Chair.

CHAIRWOMAN SAVAGE: I vote yes, based on the State Board's staff report and testimony today. And I echo what Dr. Martell has said.

MR. JONES: Project has received seven approved votes, one no.

CHAIRWOMAN SAVAGE: Thank you. So this motion is approved, and your permit is effective today, but you will be receiving a permit letter outlining the confines of the project as well as all post-permit requirements.

MULTIPLE SPEAKERS: Thank you.

CHAIRWOMAN SAVAGE: So next on our agenda will be project H-0223-006 HSHS St. Mary's Hospital.

If you could introduce yourself and be sworn in, please?

MR. LAWLER: Yes, my name is Dan Lawler with Barnes and Thornburg. I am the CON consultant for the applicant St. Mary's Hospital and the Hospital Centers Health System.

Whereupon,

DAN LAWLER,

being first duly sworn or affirmed to testify to the

truth, the whole truth, and nothing but the truth, was examined and testified as follows.

CHAIRWOMAN SAVAGE: -- if you'd like to proceed.

MR. LAWLER: Yes, thank you, Madam Chair. Recent years have not been the best of times for rural hospitals and health systems, far from it. Declining utilization, declining reimbursement, high inflation, supply delays and shortages, high labor costs and even declining populations which is the case in Decatur.

But the hospital sisters are fully committed to maintaining St. Mary's. Later this year they intend to file with this board an application for a nine million dollar modernization project at St. Mary's. That project will fit the hospital to our new realities and provide for smaller more efficient bed units and demolition of unused antiquated space.

But before that, we have this application to discontinue service lines that are highly underutilized and can no longer be viably maintained or even staffed. The hospital sisters have operated lost -- operating losses at St. Mary's in each of the last five years totaling over 60 million dollars. The most recent fiscal year accounted for almost a third of that at

nearly 20 million. That is not sustainable. This application will help St. Mary's continue as a viable healthcare facility that can be rebuilt into a modern facility suited for the population it serves and the financial circumstances it faces.

The discontinuation of these services will not result in a bed need for any line of service. The staff report shows that each service line will continue to have excess beds in the planning area after this discontinuation. All of the other area providers are currently underutilized in every service line with excess capacity to handle additional volume.

We are grateful to your staff for the technical assistance provided. The determinations in the staff report that there are no negative findings and that the project is in conformance with the board's regulations. The hospital sisters are also appreciative of the other providers that submitted written comments in support including Crossing healthcare, Heritage Behavioral Center, Memorial Health System, and OSF HealthCare.

I'd be glad to answer any questions the Board may have before I request an applicant deferral of the project.

CHAIRWOMAN SAVAGE: Mr. Kniery.

MR. KNIERY: Thank you Madam. Madam Chair and board members, without objection, I'd like the record to acknowledge that provided to each board member today and to the applicant today is a letter from the Department of Human Services through its ex officio member, and the Secretary of DHS. -- questions.

MR. LAWLER: Madam Chair, may I make just a brief comment on this letter?

CHAIRWOMAN SAVAGE: Certainly.

MR. LAWLER: I would just like the Board to know that this application was filed in early February and throughout the pendency of this application, there have been meetings in the -- with Decatur area providers of acute mental illness services, and outpatient mental illness services including at Crossing healthcare and Heritage Behavioral Health. And multiple members of a number of state agencies are participating in those meetings, including representatives of the Department of Human Services, the Department of Healthcare and Family Services, and the Illinois Department of Public Health. And St. Mary's has been through its CEO, Teresa Rutherford, has participated in all of those meetings.

At no point was it ever suggested to her that

there was a linkage between those meetings and this pending application. Somebody has made that linkage. We will continue to participate and collaborate with local providers and the state, and so we just want to let you know that concerns, there are meetings addressing these issues that St. Mary's is participating in -- other area providers.

CHAIRWOMAN SAVAGE: Okay. Any questions by the board members? Mr. Budee.

MR. BUDDE: What's the projected impact on the income statement by these changes in the last from 2022 -- just under 20 million dollars from operations?

MR. LAWLER: It is still going to be difficult reaching an operating in the positive, but the hospital sisters are committed to maintaining that process indicator and that hospital. So what I'm trying to say is that this discontinuation is not going to cure all the operating issues, there will be challenges going forward there.

MR. BUDDE: I'm assuming in terms of in addition to the losses that we show -- take two during that time period, hospitals received additional monies from the federal government, the State government and things like that, so you're -- had you not received

that, do you happen to know what the total of those kind of one-time payments for --

MR. LAWLER: Sir, I -- I don't. Those -- those numbers would've accounted for those payments.

MR. BUDDE: Right. Absolutely. I guess my point is, the actual day-to-day impact on the hospital had you not received those payments would've been substantial.

MR. LAWLER: Substantial, yes.

MR. BUDDE: How come nobody from the hospital is here?

MR. LAWLER: I had a conversation with your staff. We had requested a deferral last -- we explored deferral of the project under your board's rules of a technical requirement that a written applicant deferral has to come in within five business days of the board meeting, and we had no reason to expect a deferral prior to that, and so given that we were not within the five business days, the only other way of requesting a deferral from this board was for me to appear and orally request it. So you know, we didn't -- because we anticipated the deferring today, we did not want to have people drive up from Decatur and Springfield for this.

MR. BUDDE: Last question, have -- you know,

the closing the -- program and things like that -- is this been well coordinated, because we had -- we had some real problems in our region, because there wasn't -- shutting down these services, and so is Decatur Memorial prepared to on some certain date pick up the ball and run and patients transfer --

MR. LAWLER: So St. Mary's has been in communication with Decatur Memorial since before the filing of this application, specifically, with regard to the obstetric services. And Decatur Memorial has provided a written letter in the record indicating that they're available to pick up those services and we've also been in communication with the Memorial Hospital in Springfield which is less than --

CHAIRWOMAN SAVAGE: Ms. Waller.

MS. WALLER: Madam Chair, I would propose that given the hospital staff who would be critical to many of the questions that we would have regarding this testimony that we table this particular project today, and take the application for the deferral and then revisit it at another time.

CHAIRWOMAN SAVAGE: Yes, that is what we're doing.

BOARD MEMBER: Mr. Kaatz.

MR. KAATZ: Madam Chair, Madam Chair, it is the applicant's right for deferral and he has requested that, so there is no need for a motion for this.

MR. LAWLER: Yes, that -- just to clarify the record, the applicant is requesting a deferral to the June 4 meeting.

CHAIRWOMAN SAVAGE: Thank you very much. We'll see you when you return back with your folks from HSH [ph]. All right. So at this time we're going to take lunch. And then we'll return with the project on 23-014 for Exceptional Care and Training in Sterling. We'll be back at 1 o'clock and then we will proceed.

(Off the record.)

(On the record.)

CHAIRWOMAN SAVAGE: So next up on our agenda is H-04 Project 23-014 Exceptional Care and Training Center. So may I have a motion to approve Project 23-014 for the establishment relocation of this facility of this medically complex -- development -- population, a motion.

BOARD MEMBER: So moved.

BOARD MEMBER: Second.

CHAIRWOMAN SAVAGE: Okay. You folks are here, so if you could introduce yourselves, spell your names

and then be sworn in.

MS. COOPER: Anne Cooper CON counsel for Exceptional Care & Training Center. A-N-N-E, C-O-O-P-E-R.

MR. SMITH: Doug Smith, D-O-U-G, S-M-I-T-H.

MS. FRANCQUE: Melissa, M-E-L-I-S-S-A, Francque is F-R-A-N-C-Q-U-E.

MS. BARACH: Andrea Barach, A-N-D-R-E-A, B-A-R-A-C-H.

MR. SCANLON: Rich Scanlon, R-I-C-H, S-C-A-N-L-O-N.

THE COURT REPORTER: Will you all raise your right hand?

Whereupon,

Anne Cooper, Doug Smith, Melissa Francque, Andrea Barach, Rich Scanlon,

being first duly sworn or affirmed to testify to the truth, the whole truth, and nothing but the truth, was examined and testified as follows.

CHAIRWOMAN SAVAGE: Don, can you -- please?

MR. JONES: Madam Chair and board members without objection, I'd like the record to acknowledge that prior to the Board and that there's a letter from the Department of Human Services through its ex officio

member of the Secretary of DHS supporting the project.

CHAIRWOMAN SAVAGE: Thank you. -- the staff report, please.

BOARD MEMBER: The applicants operate the 85-bed skilled nursing facility for medically complex individuals with developmental disabilities, located in Sterling, Illinois. The applicants are proposing to establish an 85-bed MC/DD facility in the same city. The proposed facility will be six minutes from the existing facility in a predominantly residential area close to CGH Medical Center.

The new facility will consist of 49 -- 49,600 -- square foot, with an estimated cost of 27.1 million dollars. Should the State Board approve this project, the applicants will discontinue the current 85-bed facility located as 2601 Woodlawn Road in Sterling, and since the State Board does not have jurisdiction over discontinuation of long-term care facilities. The State Board staff note that there are two negative findings. The report shows three, but the first quarter recommendations from state departments was resolved per the letter we received. The other two are both financially based. Financial viability and reasonableness of project costs. Thank you.

CHAIRWOMAN SAVAGE: Thank you. -- if you'd like to proceed.

MS. FRANCQUE: Good afternoon. I am Melissa Francque, executive director of Exceptional Care and Training Center or ECTC for short. With me are Doug Smith, our president, Andrea Barach, our vice president and general counsel, Rich Scanlon, senior managing director investment bank ing, senior living at Ziegler and Anne Cooper, our CON attorney.

I'd like to thank the State Board staff for the mostly positive State Board report and technical assistance during preparation of our certificate of lead application. Since the Board is most likely not familiar with ECTC or the residents we proudly serve, I would like to provide some background on who we are.

ECTC has provided assistance and services for persons with severe and profound intellectual disabilities since 1979. I have been part of the ECTC for nearly 30 years and have served as executive director since 1998. Suffice it to say, working with our residents to help them live a full life is my position.

At ECTC we provide 24-hour nursing care to residents who suffer from genetic disorders, birth

trauma, accidents, physical abuse, and/or debilitating or life threatening diseases. We can provide intravenous therapy, gastrostomy tube feedings, oxygen administration, and palliative and end of life care. Additionally, we offer physical, occupational and speech therapy.

Importantly, we are one of only ten facilities in the State of Illinois that serve this specialized population. Unlike traditional skilled nursing facilities that serve geriatric populations where the average length of stay can be several months to a couple years, for many of our residents ECTC is their home. Spending an average over 20 years at our facility. Many of our residents have been with us since 1988 [ph].

This project has further relocation of ECTC to a location approximately 2.6 miles from its current location. The existing building is over 58 years old, and constructed when care was provided in an institutionalized setting. At the time it was built, there was little commercial activity in the surrounding area. The town has since grown and the neighborhood now consists of retail, fast food restaurants, and business offices. The building now sits off a four-lane highway and a busy intersection. Further, the building was

originally built to be a geriatric community, not for ECTC specialized populations.

Upon entering the impression as institutional and cramped. Despite the staff's best efforts to brighten the residents' rooms with color and decor. Two resident rooms are predominantly -- with communal bathing, toilet rooms in the hall.

Further, the physical plant is inadequate for operations. The resident rooms are inadequate to accommodate the necessary equipment to treat the residents due to larger customized wheelchairs and other adaptive devices, oxygen -- oxygen therapy equipment, gastrostomy feeding poles, positioning equipment, bed safety mats, alternative seating in lieu of wheelchairs.

The kitchen is in the basement and there is no elevator, and the dumbwaiter lacks sufficient capacity to transport food so staff must travel up and down a rather narrow staircase -- deliberate care of residents -- and clear residents' meals.

There is insufficient storage areas for wheelchairs and other adaptive equipment which hinders operational efficiency for the clinical staff. Hallways are fairly narrow with low ceilings. And limited space exists for day training and education.

Finally, the existing campus is landlocked. And as the building and outdoor recreation areas cannot be expanded. The new facility will be a single-story modern facility and more spacious. It will promote staff efficiency by minimizing the distance of necessary travel between frequently used spaces and allow easy visualization of residents by staff.

Further, the new design will provide a positive environment for residents with more residential care -- characteristics. There will be additional areas to accommodate visitors, training and consultants. The resident care units will focus on the individual. Triples will be replaced with semiprivate rooms, and communal bathing and toilet rooms will be replaced with separate bathing and toilet rooms between every two rooms which will include carefully designed sight lines to ensure resident dignity and privacy.

The day training and educational areas will be centrally located in the building to minimize unnecessary traffic in the residential living areas. The classrooms will be larger rooms to allow for safe and motor exercises and activities. It would also allow for space for a resident to simply move away from others if they need some time to be by themselves.

The new building will allow for more space in residential, educational, and outdoor areas to facilitate a multisensory approach to resident active treatment. For ECTC residents, this means giving them the opportunity to explore and learn about the environment around them. To enable them to interact with it and most of all to be given respect.

Sensory spaces throughout the building will provide enjoyable sounds, music, facilitating light displays, and aromas, and contrasting textures all designed to simulate the primary senses and induce feelings of peace and relaxation.

Multisensory programming improves tests, concentration and self-awareness, improves interaction and communication, encourages exploration and stimulation of the senses. It promotes a closer connection between our clients and our caregivers and helps to decrease the maladaptive and self-interest behaviors.

We are excited to provide our residents with a modern and spacious facility that will allow them to make their story a happy one. Thank you for your time, and I would like to hand the presentation to Doug Smith who will provide background on Hudson Woods. Hudson and

our financial --

MR. SMITH: Thank you, Melissa, and good afternoon. I'm Doug Smith, president of Hudson Wood, the parent organization of Exceptional Care and Training Center. Since we've not been before this Board before, I wanted to provide you with some background on our organization and our commitment to care for so many most vulnerable individuals in the community we serve.

In 1988, two friends Dr. Bruce Hudson and Lewis [ph] Wood formed Hudson Wood, a nonprofit organization to save four communities out of bankruptcy, ECTC being one of those. Since that time, our organization has grown to include eight nursing homes and assisted living communities in Illinois, Indiana and Tennessee along with 14 affordable housing communities in Tennessee and Georgia.

Today Hudson Wood is a network of vital local communities that provide long-term health and housing solutions. We're dedicated to offering senior healthcare services, long-term care for children and adults with disabilities and affordable housing.

Our mission is to serve the healthcare and shelter needs of our local communities in a compassionate and respectful manner. And our vision is

to enhance the lives of the people we serve by providing high quality healthcare and shelter services.

And at the heart of it all, our core values, compassion, integrity, quality, community, innovation and empowerment. ECTC is one of our three long-term disability communities in Illinois which support the long-term needs of children and adults with significant physical and developmental disabilities like folks have just described.

We are a collection of talented individuals who are not just working for a company, but are trying to make a difference in the world. And we try to make their story a happy one. I would like to assure this board that we have the financial resources to complete this project. With respect to the financial viability, our current ratio which is a measure of the company's liquidity or ability to pay their short-term obligations exceeds the State Board standard of 1.5. And our day's cash on hand exceeds the 45-day standard.

As discussed in greater detail in the notes of our audited financial statements which were included in the application as of June 2022, we had nearly 20 million in financial assets available for financial expenditures.

As part of our liquidity management plan, we invest our excess cash above our daily requirements insecured and insured financial investments. Our goal is to maintain sufficient cash on hand to meet the 45 days of normal operating expenditures and to structure our financial assets to be available as general expenditures, liabilities and other obligations come due.

I have personally worked with Ziegler and Rich Scanlon, the senior managing director who represents Ziegler today on numerous projects going back to 2008. Their reputation as an investment banking firm focused on the senior living sector is unmatched and Hudson Wood values their insights of the capital markets.

Granted the capital markets are in somewhat of an unsettled time these days, factors beyond our control, we anticipate we will be able to secure financing for this project for the physically and developmentally disabled children and adults throughout the State. Thank you for your time, and I would like to hand the presentation to Anne Cooper to discuss the negative finding.

MS. COOPER: Thank you, Doug. I'm Anne Cooper, attorney for Exceptional Care and Training

Center. Before I address the negative findings, I'd like to thank the board staff for expediting the consideration of this application and the mostly positive State Board report.

This project meets all the Board's review criteria with the exception of financial viability and reasonableness of construction costs. With respect to financial viability, it is important to understand most existing healthcare facilities cannot meet all the financial viability ratios for each year.

The financial viability ratio ECTC failed to meet pertaining historical debt service. Importantly, bond transactions which is how this project will be financed generally do not start testing the debt surveys coverage and other ratios until the first full year of stable occupancy which in this case would be 2026 when ECTC meet s all the financial viability ratios.

ECTC did not meet two of the six financial viability ratios. Percent of debt to total capitalization and projected debt service coverage. The percent of debt to total capitalization is an indicator of a company's leverage which is debt needed to purchase assets or in this case, used to construct new assets.

The State's -- is 80% or less. Over the most

recent three years, the percent of debt to total capitalization at ECTC facility has declined and it's projected to fall to 70% by 2026 -- project completion.

The debt service coverage ratio is a measurement of a company's available cash flow to pay current debt obligations. The debt coverage service ratio of less than 1.0 indicates the company may have solvency issues. The State's -- is greater than 1.5. Here, ECTC had a debt service coverage ratio of greater than 1.0 in each of its historical years reporting, and 90% of debt to total capitalization continues to improve each year exceeding the State's standard by 2026.

Whether -- analyses to determine financial viability, days of cash on hand is perhaps the best indicator of an entity's ability to meet operating and capital expenses. The State standard is 45 days and each year ECTC significantly exceeds that threshold. And by 2026, ECTC projects it will have over 240 days of cash on hand. In -- ECTC is financially stable, and has more than sufficient financial resources to complete this project.

The last negative finding is on the reasonableness of project costs which is the result of construction costs exceeding the State's standard. This

is due in part to the fact that there are no cost standards specific to MCE facilities, so the State standard for long-term care facilities are applied. Importantly, due to the specialized care and equipment needs of the residents and -- facilities are more expensive to build than typical skilled nursing facilities.

Specific to this project, the installation of overhead ceiling -- transfer and build -- service classrooms which will allow ECTC to provide more programming to residents have contributed to the increase in construction costs.

Furthermore, the construction budget that was used in the CO1 application is based on historical costs. Due to rising labor and supply costs, ECTC was conservative and included an additional cushion of budget to ensure that it does not come to the -- back to this board for an alteration to include the budget once the project is out for bid in about six months.

Thank you for your time and attention. We're happy to answer any questions you may have at this time.

CHAIRWOMAN SAVAGE: Thank you. Board members, do we have questions for this applicant? Mr. Kniery.

MR. KNIERY: [Inaudible] can you talk -- tell

us a little bit about MC/DD, it's under 22 years of age typically, so just walk us through your average age of typical residents and what do you do when residents age out of I believe -- probably keep them?

MS. FRANCQUE: Historically, it was under 22. About seven years ago they changed the licensure application from skill ed pediatric for under 22 to the MC/DD medically complex for development -- mentally disabled. They did not have an A frame or -- so zero to 120.

MR. KNIERY: So what is your average age?

MS. FRANCQUE: My average age at my facility is, I'm going to say about 45.

CHAIRWOMAN SAVAGE: Other questions.

MS. LEGRAND: I have one.

CHAIRWOMAN SAVAGE: Sure.

MS. LEGRAND: So I'm speaking from someone who's had a family member in one of these, but in a different state. Your -- I'm sorry. Am I not close enough? I got a big mouth.

The restrooms, you had mentioned that they were going to be like in each of the bedrooms or is it going to be like at the end of the hall, a shower area or how are you --

MS. FRANCQUE: Currently, they are in the hall as a communal showering area. Each of the bedrooms currently does have a restroom, but it's not a shower room.

MS. LEGRAND: Okay.

MS. FRANCQUE: In the new design, it -- the bathing unit will be between -- it'll be a suite. So there will be two bedrooms sharing the one bathing area. It will not be in the hallways.

MS. LEGRAND: Will you have in their like a like big dining hall for them to go into in the -- in the area where you will also do like some PT, OT in that area or will you have separate rooms through all of that --

MS. FRANCQUE: Yes. We will have in the main day training area, it will have classroom areas and -- areas there. That's where we will be doing the therapies and the sensory, multisensory rooms.

CHAIRWOMAN SAVAGE: Mr. Budee.

MR. BUDDE: Yeah, just -- what is your amenity -- on your chart -- Table 5 where it shows the different ratios of days cash on hand and things like that are you going to take on part of the financing this is the 25 million dollar loan; right? Is that correct?

MR. SMITH: Correct.

MR. BUDDE: That's not refinancing or anything else, that's new debt to fund the construction of this facility?

MR. SMITH: Yes.

MR. BUDDE: How -- and you're kind of replacing debt for debt in terms -- you're not creating a larger facility, you're just mock -- creating --

MR. SMITH: Well, the size of the facility itself is almost double.

MR. BUDDE: I mean, in terms of numbers of rooms, you know.

MR. SMITH: Number of beds is steady -- center.

MR. BUDDE: Okay. How, then is your -- are your ratios getting better when you're taking on 25 million dollars in debt particularly, you know the debt service coverage and are you anticipating an increase in reimbursement or it's --

MR. SMITH: We're seeing some increasing reimbursement now from the State. I know there was a proposal from the State based on the acuity levels that will go up. The State is usually I think like this, it's been every six years. The last increase was 2019.

So they're going -- there's talk about them increasing again and then starting to do that every -- every year.

MR. BUDDE: Okay. Is there a particular reason, because you know, you have some pretty substantial improvements like debt service coverage going from 1.07 in 2020 to 1.72 and days cash on hand going up pretty considerably. Are you comfort with that, because --

MR. SMITH: Yes.

MR. BUDDE: -- concerned about taking on 25 million dollars in debt and are you going to be able to service that debt in a couple years when the facility is up and running and -- or is it going to put a burden on the facility. The ratios would indicate not, but we just can't -- I'm an old CFO --

MR. SMITH: No. I understand. We are -- I -- you know, I have to be honest, our VP of finance helped put this projection together and he's very detail oriented. But based on how he runs and Melissa knows from doing budgets with him of running the rates, the rate increases, they're expected that the State has talked about running that through these whole -- through these whole projections.

MR. BUDDE: Okay. Thank you.

CHAIRWOMAN SAVAGE: Other questions? All right. Don, if you could call the roll.

MR. JONES: Mr. Budee.

MR. BUDDE: Yeah, based on the report, staff report and -- and, you know your devotion to taking care of these kinds of patients, I certainly vote yes, in fact, you want to create a nicer facility for them, thank you for that.

MR. JONES: Mr. Fox.

MR. FOX: Yes, based on the staff report and applicant testimony.

MR. JONES: Mr. Kaatz.

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

MR. JONES: Ms. Legrand.

MS. LEGRAND: I also vote yes, based on the staff report and the presentation. And thank you for what you're doing. Having a sister who needed a place like this, thank you so much.

MR. JONES: Dr. Martell.

MS. MARTELL: Yes, based on the staff report and testimony today.

MR. JONES: Ms. Hardy-Waller.

MS. WALLER: I'll -- I'll vote yes, based on

the staff report. I do have similar concerns about the debt ratio and how you will manage that over time, but because of the work that you do, it's so important, so I -- I vote yes.

MR. JONES: Dr. Tanksley.

MS. TANKSLEY: I vote yes, based on the staff report and the testimony given today.

MR. JONES: Chairman Savage.

CHAIRWOMAN SAVAGE: I'd like vote yes, based on today's testimony and the State board's staff report, and thank you for your work with this fine --

MULTIPLE SPEAKERS: Thank you.

CHAIRWOMAN SAVAGE: Thank you. So that motion is approved, and your permit is effective today, but you will receive a permit letter outlining the confines to your project as well as all of those permit requirements. Thank you.

MULTIPLE SPEAKERS: Thank you.

CHAIRWOMAN SAVAGE: All right. Next up on our agenda is H-09 Project 23-010, Advocate Outpatient Center. May I have a motion to approve project 23-010 for the establishment of this medical office building in Lakemoor HSA8.

BOARD MEMBER: So moved.

BOARD MEMBER: Second.

CHAIRWOMAN SAVAGE: Thank you. And folks, can you join us? State your names. Spell your names, and you will be sworn in.

MR. ROSE: Hello, Landon Rose, L-A-N-D-O-N, last name is Rose, R-O-S-E.

MR. MESSINA: Good afternoon, Peter Messina, P-E-T-E-R, M-E-S-S-I-N-A.

MR. GORDON: Good afternoon, Trent Gordon, T-R-E-N-T, G-O-R-D-O-N.

THE COURT REPORTER: Would you all raise your right hand.

Whereupon,

LANDON ROSE, PETER MESSINA, TRENT GORDON,

being first duly sworn or affirmed to testify to the truth, the whole truth, and nothing but the truth, was examined and testified as follows.

CHAIRWOMAN SAVAGE: Thank you. George, if you could give us our State Board staff report.

MR. ROATE: Thank you, Madam Chair. The applicants propose to establish a single story medical office building in Lakemoor. The new single story building will house primary care and specialty -- specialty care clinician offices for Advocate Medical

Group and nonhospital based outpatient services including physical therapy, lab imaging and integrated medicine and retail drive-through pharmacy.

The cost of the project is approximately 29.6 million dollars. The anticipated project completion date is October 31, 2024. There were two negative findings, permit to § 1120 -- rules and the applicants did explain new construction and site prep premiums located on Page 12 of your report.

CHAIRWOMAN SAVAGE: Thank you. Would you like to proceed?

MR. ROSE: Thank you. Good afternoon board members and staff. I'm Landon Rose, vice president of operations for Ambulatory Services and service lines in Northern Illinois for Advocate Health. Also here with me today are Trent Gordon, vice president of business development for north Illinois, and Peter Messina, regional director of design and construction for Ambulatory Services.

Thank you to the board staff for the time and assistance review of this project. Behind us today are other leaders of Advocate's team included in a project. They are here to provide any details or answer any questions you may have.

This project is for the development of a single story 20,000 square foot outpatient clinic in Lakemoor, Illinois which will house primary care providers, women's health and behavioral health services. We decided this additional outpatient building was necessary because the closest Advocate Medical Group location in Wauconda cannot accommodate additional clinicians or patients and as Trent Gordon will fully describe, our community health needs assessment supports the development of additional primary care services in this area.

As some of you may know, the Lake County population has grown exponentially in the last 30 years by about 200,000 people or 40%, with most of that growth in the north and west regions of the county. Historically, most of the healthcare resources in the county were focused along the southeast parts of the county.

Often, it is difficult to grow a provider base when there isn't a hospital in the ED area, but we are making strides to increase provider access to patients living in this part of the county with our hospital Good Shepherd located approximately 20 minutes away as a hub of care for our outpatient initiatives.

For services that are most in demand on an outpatient basis, we want our patients to be able to obtain those services close to home when possible. This is a growing area with new economic and housing developments with limited healthcare providers in Lakemoor and the surrounding communities such as -- this facility will partner the new retail area being developed to support this growing population.

The space will include physician exam rooms for Advocate Medical Group physicians and advanced practice clinicians that brings needed primary care, women's services, behavioral health services and other specialties. The building will include nonhospital based outpatient services including general radiology, ultrasound, physical therapy, integrative medicine, and lab services. This facility will also include our retail drive-through pharmacy. The new facility will provide full location of physician offices with the ancillary services that are often required as part of an office visit to improve care coordination benefiting patients in one location.

It is often challenging to access appointments with existing primary care physicians in this area. The two closest Advocate Medical Group offices have

clinicians that are at capacity. This will improve availability for primary and specialty physicians closer to residents in these communities.

We appreciate the positive staff report and I would like to introduce Trent Gordon who will talk about how we determine new projects location and focus services based on the needs of the community.

MR. GORDON: Thank you, Landon. It's a pretty important week for healthcare and hospitals and so Landon and Peter and I wanted to wish all the Advocate nurses a happy nurses week and any nurses who may be in the room as well.

So as Landon referenced, my name is Trent Gordon, I'm the vice president of business development for North Illinois. And the last time we were in front of you, Dr. Tanksley had asked about how we decide where we choose where we note or locate new clinics as well as how we decide what to put into those new clinics, so we wanted to proactively address that question today.

So we use a number of different quantitative and qualitative metrics in our decision-making process. So one of our guides that bridges both the quantitative and the qualitative arena is our hospital's community health needs assessment. Which we conduct every three

years. So the CHNA as it's known, helps us identify needs in the community, incident rates of disease, if those incident rates go up, if they're going down, and then resource needs for our residents as well.

So I'm looking at Good Shepherd's CHNA, we found the following, so relative to location where we are planning to build this clinic, the number of primary care physician s is low and unfortunately decreasing and there is a need to provide resources for patients suffering from heart failure, to address the rise in hypertension, to address the rise in cervical cancer rates and there is also a need to develop outpatient mental health resources to reduce unnecessary visits to the emergency department when early behavioral health screening and intervention in the primary care setting can greatly benefit those patients.

So in general, we identified primary care access including obstetrics, preventative services, mental health services to be imperative as it relates to this project. Also through focus groups, we interviewed residents about their healthcare needs and their care preferences. So beyond access to primary care services, we found that residents are more often using integrated medicine clinicians such as acupuncturists,

chiropractors, a massage therapist, in addition to or in lieu of traditional medicine. So these patients want their integrated medicine and clinicians practicing alongside their primary care physicians and not in different locations. We received such positive feedback from the area community representatives that this clinic is needed, we're anxious to move forward to begin construction to make this service available as soon as possible. Advocate Health will continue to invest in the service area to continue to provide high quality outpatient care to the communities in the service area.

Finally, relative to deciding on developing a clinic in Lakemoor, we also work with an outside company which calculates physician demand and physician supply in a specified geography actually by specialty. What we found is that there are very few to no positions to five nearby Zip codes which means that residents need to travel for basic care. It should come as no surprise that residents shared with us that they would like to receive their care close to home.

Thank you for considering this planned clinic. I would like to introduce Peter Messina who will now speak to the staff's findings surrounding the project's anticipated costs.

MR. MESSINA: Thanks, Trent. Again, Peter Messina, director of design and construction for ambulatory services for Advocate. I actually have oversight over the development of the plan project once we have the ability to move forward, and I just want to thank again, the Board Staff for the time that was put in to help answer questions and talk through, you know, as we develop the application.

I would like to review the State's staff report findings which relate to cost and the fact that they're higher than the State's standards. The Lakemoor Outpatient Center's costs include necessary expenses that are beyond the typical clinic building. There are a few main reasons for that. Significant site requirements that are atypical to the normal site development project. A relatively small building footprint. Recent cost escalations in the construction industry that week do not warrant and we need to address the developing sound application and project.

I should mention and I'm sure the Board can appreciate that by allocating capital resources, Advocate is interested in maximizing the utility of our buildings without paying more than is absolutely necessary to get the facilities up and running. And to

keep them well maintained. We must be good financial stewards of healthcare resources and we believe we are with this project that we have put forward.

So I want to provide some more details around these three areas of impact that are driving the -- from the State's standards. The first work we do, of course, is the site preparation, and the outside configuration. It's quite unique and extensive for this project as part of our land purchase agreement, there is a homeowner's association, and we're required by that HOA to construct an access road that connects the two retail parcels that are on either side of our development. That road is separate and apart from what is actually needed for our own development for the clinic.

We are creating an additional vehicular driveway to split the drive-up retail pharmacy that will be located in the building. And the earth work, the movement of earth is extensive to bound this site, reduce haul off of soil, while also raising our building by presence and give visibility to the patients and the community driving by. These items and their, you know, inherent values are included in the State's staff report.

Another key contributor to the project cost is

the scale and the type of the project. It is a fact that in the construction industry that a bigger building -- lower cost per square foot, because of the fact that certain fixed costs that need to be borne regardless of the size of the building cannot be spread over a larger area -- larger square footage. And for a small building that does have an impact in the visibility of you know, would that cost per square foot looks like.

Our building at just under 19,000 square feet, actually 19,270 square feet, this Lakemoor Outpatient Center will be less than a third of other Advocate and non-Advocate Medical Office projects the Board has considered in recent months. Our Lakemoor project is also new ground up construction which includes building foundations, steel structure, the envelope of the building, so the walls, the grazing [ph] systems, the roof, where other medical office projects were interior renovations, but also defined by the state as new construction. So a big difference between new construction that's interior renovation, and new construction that is actually a brand new building, but the -- means standard does not fully differentiate those two types that obviously, there's much more cost

associated with a new building. These factors are important to point out, because they require more different building components than an interior renovation project where a shell building already exists.

Additionally, these ground up construction projects come at a higher cost, and for our project those costs again, are spread across a very small footprint.

In addition to the overall building square footage, it's relevant to point out an association with the construction of a smaller key room than your state standards allow for. So each of the clinic, well, imaging services are in a room that are reviewable that have state standardized rooms where the square footage is well below the State of Illinois maximum standard size. These spaces are big enough for their intended purpose, but very efficient. For example, our ultrasound room is 191 square feet. Much lower than the State maximum at 900 square feet for an ultrasound room.

These efficiencies and building layout result in a lower denominator or square footage for that individual room, yielding a higher dollar per square foot -- room, if they require -- still the standard.

Also, imaging rooms have special construction required to make the surrounding room safe from radiation. A higher dollar per square foot is attributed to, in part, to web [ph] shielding, structural support for equipment. Infrastructure requirements like increased electrical capacities, humidification to make sure that the room -- the unit -- equipment does not break down. And other imaging-specific requirements.

Within the State staff report and in our application, we also provide an itemized list of project-specific medical office building components needed to support operations at our facility that are required that we consider essential, but premium cost to what you would find in the RS means standard calculation. Some examples of those are our onstage, offstage design model. It's a very standard model for medical office clinics these days. But it allows us to separate the patient flows from the physician flows and create a better patient experience and faster throughput for -- for the states, itself.

Generator infrastructure, and what is known as a hydronic mechanical system, it's a -- this is in comparison to needing an electrical reheat mechanical

system. The hydronic system actually allows us to reduce and return -- return energy consumption. It does come at a higher cost.

And the last point, and I've articulated this at -- I asked -- the recent board hearings is related to the construction escalation. Material escalation has almost tripled in the last year and reports continue to support hyper-escalation that's beyond the -- current contractor pricing indicates that bid price escalation is approximately 29% average across various trades from what we've seen over the last two years.

I know certain new hospital facilities have been criticized for construction -- constructing new buildings with lavish finishes and unnecessary grand design elements. This would not be anything like that. The finishes we've used will be functional and durable. We will build a building that is meant to last and meet the intended purposes of this clinic. And if we can't find cost savings along the way, we will bring this project under budget in the year actually since we made the application back in February. We have been working towards that -- towards bringing our costs down more on track for that. And no one will be happier than me to report that we do come in under budget, even for

somebody in the construction industry, it is a very alarming and hard to believe how exorbitant our construction costs are -- just in comparison to what we've seen in the year and a half or two years ago.

And just in closing, I think it's important to mention that we do intend as we do with all of our projects at Advocate, we have an opportunity to ensure that our construction -- going towards trade companies and contractors and the labor community that are minority and women-owned businesses, we have an actually minimum requirement for a project of 25% of our -- going towards diverse contractors and companies, and again, that is one of the goals that we plan to achieve with this project.

So I'd like to thank you again for the opportunity to speak today, and would be happy to address any of your question s.

CHAIRWOMAN SAVAGE: Any questions of board members? Mr. Fox.

MR. FOX: Question for Mr. Messina. For the construction costs how much is the growth and cost related to material costs as compared to labor costs and I'm imagining that there's a demand for lots of construction labor these days as the many projects have

been withheld until the last 24 months ago, so --

MR. MESSINA: Yeah. Very good question. And it actually depends on the trade itself. We've seen certain trades like metal studs and drywall be over 75% material cost escalation. There are some trades that are over 100% escalation. On average, as I mentioned, in the last two years, it's been about 20% overall both material escalation and labor, but labor is a component to it, I would say the majority of it though is material.

MR. FOX: Thank you. And then a question for Mr. Gordon. It's even -- it's only a semi-related question that is, will this building be built in a shopping center or near other commercial property?

MR. GORDON: Yes. So the property is -- the land is actually owned by the grocery store Woodman's. And it will be in a relatively new shopping center, so right now, in the area where it will be built, will be about 200 feet from the Woodman's. Currently in that shopping center, there's a Taco Bell, Chipotle, Starbucks, a couple of different gas stations. So it will be in a retail area, and it's still -- they're still selling parcels and still growing the property as well.

MR. FOX: So it sounds like you've chosen wisely with the -- and increase in traffic area, so --

MR. GORDON: Yes. Yeah, no, thank you, we look at traffic patterns, travel patterns, commuting patterns in this -- and that was another reason that we chose the property that we did, yes. Thank you.

CHAIRWOMAN SAVAGE: Other questions?

BOARD MEMBER: -- to that question, is this going to be a lease agreement or do you -- have you purchased the land in the shopping center.

MR. GORDON: We have purchased the land already, yes.

CHAIRWOMAN SAVAGE: Other questions? Okay. Don, if you could call the roll.

MR. JONES: Mr. Budee.

MR. BUDDE: Yes, based on the staff report and the presentation today, I vote yes.

MR. JONES: Mr. Fox.

MR. FOX: Yes, based on the staff report and applicant testimony.

MR. JONES: Mr. Kaatz.

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

MR. JONES: Ms. Legrand.

MS. LEGRAND: I also vote yes based on the staff report and presentation.

MR. JONES: Dr. Martell.

MS. MARTELL: Yes, based on the staff report and testimony.

MR. JONES: Ms. Hardy-Waller.

MS. WALLER: Yes, based on the staff report and your presentation.

MR. JONES: Dr. Tanksley.

MS. TANKSLEY: Yes, based on the staff report and the testimony.

MR. JONES: Chairman Savage.

CHAIRWOMAN SAVAGE: Yes, based on the staff report and testimony.

MR. JONES: And Chair, you have eight affirmative votes.

CHAIRWOMAN SAVAGE: Thank you. So that motion is approved, and your permit is effective today, but you will receive your permit letter outlining the confines of your project as well as all permit requirements. Thank you.

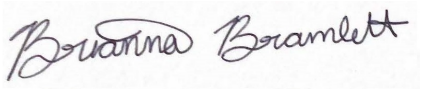
MULTIPLE SPEAKERS: Thank you.

(End of Open Session).

CERTIFICATE OF COURT REPORTER - NOTARY PUBLIC.

I, Brianna Bramlett, the officer before whom the foregoing deposition was taken, do hereby certify that said proceedings were electronically recorded by me; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 9th day of May, 2023.



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Brianna Bramlett, Notary Public
for the State of Illinois

CERTIFICATE OF TRANSCRIBER

I, Janine Thomas, do hereby certify that the foregoing transcript is a true and correct record of the recorded proceedings; that said proceedings were transcribed to the best of my ability from the audio recording and supporting information; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

Janine Thomas

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Janine Thomas

May 21, 2023