STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

525 WEST JEFFERSON ST, SPRINGFIELD, ILLINOIS 62761 •(217) 782-3516 FAX: (217) 785-4111

DOCKET NO: I-03	BOARD MEETING: August 8, 2024	PROJECT NO: 23-042	PROJECT COST: $3,490,000
FACILITY NAME: Well Care Home, NFP, INC.		CITY: Highland	
TYPE OF PROJECT: Substantive			HSA: XI

PROJECT DESCRIPTION: The Applicant (Well Care Home, NFP, INC.) proposes to establish a 74-bed long-term care facility at 100 Faith Drive, Highland, Illinois at a cost of $3,490,000. The expected completion date is September 30, 2024.

This project was deferred from the March 12, 2024, State Board Meeting and was given an Intent to Deny at the **May 9, 2024**, State Board Meeting.

On July 9, 2024, the State Board received additional information regarding this project in response to State Board Member's questions and concerns expressed at the May 2024 State Board Meeting.

Information regarding this application can be found at this link:
https://hfsrb.illinois.gov/projects/project.23-042-well-care-home-nfp.html

EXECUTIVE SUMMARY

PROJECT DESCRIPTION:

- The Applicant (Well Care Home, NFP, INC.) proposes to establish a 74-bed long-term care facility at 100 Faith Drive, Highland, Illinois in approximately 74,000 GSF of space at a cost of $3,490,000. The expected completion date is September 30, 2024. Well Care Home, NFP, INC. purchased the facility at a cost of $2,350,000.
- In September of 1999 the State Board approved a 76-bed long term care facility known as Faith Countryside Home (Permit #99-069) at a cost of $12.5 million. As part of this project there were 36 assisted living apartments. The State Board has no jurisdiction of assisted living apartments.
- In June of 2021 Faith Countryside Home closed. The closure was the result of decreased hospital discharges and falling revenues as expenses increased for staffing and supplies as a result of the public health emergency. Faith Countryside Homes filed for bankruptcy protection in East St. Louis June 15, 2021, listing assets of $1 million to $10 million and liabilities of $10 million to $50 million.

WHY THE PROJECT IS BEFORE THE STATE BOARD:

- This project is before the State Board because the project proposes the establishment of a long-term facility.

PURPOSE OF THE PROJECT:

- The Applicant states the purpose of the project is to reopen a long-term care facility in Highland, Illinois.

PUBLIC HEARING/COMMENT:

- No public hearing was requested, and letters of support were received by the State Board. No opposition letters have been received by the State Board.

SUMMARY:

- The Applicant has purchased the closed facility at a cost of $2,350,000. The Applicant addressed a total of 18 criteria and have not met the following:

State Board Standards Not Met	
Criteria	**Reasons for Non-Compliance**
1125.530 - Planning Area Need	The proposed facility will be located in the Madison County Long Term Care Planning Area and Health Service Area XI. There is currently a calculated excess of 365 LTC beds in the Madison County Planning Area.
1125.570 - Service Accessibility	The long-term care service currently exists in this planning area; therefore, the Applicant cannot meet condition number one. No evidence has been provided that the existing facilities have access limitations due to payor status; therefore, condition number two cannot be met. No evidence of restrictive admission policies at other LTC facilities in the Area has been provided; therefore, condition number three cannot be met. No evidence of medical care problems has been identified by the Applicant, therefore condition four cannot be met. The two-year average utilization of the 6 LTC facilities within the 17-mile GSA is 61% therefore, condition number five cannot be met. (See page 8 of this report)

State Board Standards Not Met	
Criteria	**Reasons for Non-Compliance**
1125.580 - Unnecessary Duplication of Service	There are six facilities within the 17-mile GSA operating at 61% occupancy. Based upon that occupancy there are 216 LTC beds available for use in this 17-mile GSA. See pages 8-9 of this report)

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Well Care Home NFP, INC.
STATE BOARD STAFF REPORT
Project #23-042

APPLICATION SUMMARY	
Applicant	Well Care Home NFP, INC.
Facility Name	Well Care Home NFP, INC
Location	100 Faith Drive, Highland, Illinois
Permit Holder	Well Care Home NFP, INC
Operating Entity	Well Care Home NFP, INC
Owner of Site	Well Care Home NFP, INC
Application Received	September 29, 2023
Application Deemed Complete	October 6, 2023
Project Completion Date	September 30, 2025
Review Period Extended by the State Board Staff?	No
Can the Applicant request a deferral?	Yes
Expedited Review?	Yes

I. Project Description

The Applicant (Well Care Home NFP, INC.) proposes to establish a 74-bed long-term care facility at 100 Faith Drive, Highland, Illinois in approximately 74,000 GSF of space at a cost of $3,490,000. The expected completion date is September 30, 2025. Well Care Home, INC. purchased the facility at a cost of $2,350,000.

II. Summary of Findings

A. State Board Staff finds the proposed project to **not** be in conformance with the provisions of 77 ILAC 1110 (Part 1110).

B. State Board Staff finds the proposed project is in conformance with the provisions of 77 ILAC 1120 (Part 1120).

III. General Information

The Applicant (Well Care Home NFP, INC.) proposes to establish a 74-bed long-term care facility at 100 Faith Drive, Highland, Illinois in approximately 74,000 GSF of space at a cost of $3,490,000. Well Care Home NFP, Inc is an Illinois not-for-profit corporation incorporated June 14, 2023. The corporation is owned by Dr. Ahsan Usman and Rabia and Ahad Usman. Dr. Usman is the CEO. Well Care Home NFP, Inc does not own any other health care facilities. The building housing the proposed long term care facility was purchased on June 14, 2023, by Well Care Home NFP, Inc. The **Geographical Service Area** for a project in Madison County is 17-miles. This is a substantive project which is subject to both a Part 1110 and a Part 1120 review.

IV. Dialysis Services[1]

The Applicant stated dialysis services will be provided by Home Dialysis Therapies, Inc. which will be located at Well Care Home, NFP. There will be six stations located at the proposed nursing home. Home Dialysis Therapies, Inc is wholly owned by Dr. Usman. Home Dialysis Therapies, Inc is incurring the expense of the dialysis equipment. The Applicant states the intent is that in the future Home Dialysis Therapies, Inc may also provide services to patients desiring to conduct treatment in their homes as well as to residents of Well Care Home, NFP. At the conclusion of this report is a list of nursing care facilities that have dialysis care stations in nursing homes in the State of Illinois.

V. Project Sources and Uses of Funds

The Applicant proposes to fund the project with cash in the amount of $3,490,000.

TABLE ONE
PROJECT COST AND SOURCES OF FUNDS

Proposed Use of Funds		Amount
Modernization	$	1,140,000
Acquisition of Property	$	2,350,000
Total	$	**3,490,000**
Cash	$	3,490,000
Total	**$**	**3,490,000**

VI. Background of the Applicant, Purpose of the Project, Alternatives to The Proposed Project

A) 1125.520 - Background of the Applicant

All applicants shall comply with the requirements of this Section, as follows:
a) An applicant must demonstrate that it is fit, willing and able, and has the qualifications, background, and character, to adequately provide a proper standard of LTC service for the community. [20 ILCS 3960/6] In evaluating the qualifications, background, and character of the applicant, HFSRB shall consider whether adverse actions have been taken against the applicant, or against any LTC facility owned or operated by the applicant, directly or indirectly, within three years preceding the filing of the application. An LTC facility is considered "owned or operated" by every person or entity that owns, directly or indirectly, an ownership interest. If any person or entity owns any option to acquire stock, the stock shall be considered to be owned by that person or entity. (See Section 1125.140 for the definition of "adverse action".)

Well Care Home NFP, Inc is an Illinois not-for-profit corporation incorporated June 14, 2023. The corporation is owned by Dr. Ahsan Usman and Rabia and Ahad Usman. Dr. Usman is the CEO. Well Care Home NFP, Inc does not own any other health care facilities. The building housing the proposed long term care facility was purchased on June 14, 2023, by Well Care Home NFP, Inc.

[1] The State Board does not have jurisdiction of dialysis services in a nursing home. 20 ILCS 3960/3 (5) (B) – "*This Act does not apply to a dialysis unit located in a licensed nursing home that offers or provides dialysis-related services to residents with end stage renal disease who have elected to receive home dialysis within the nursing home.*"

Dr. Ahsan Usman has been in a medical practice as a physician since 2003. Dr. Usman has been caring for patients for the last twenty years and has been medical director for nursing homes. Based upon the information provided the Applicant appears to be fit, willing and able, and has the qualifications, background, and character, to adequately provide a proper standard of LTC service for the community.

B) Section 1125.320 - Purpose of the Project

The purpose of the project is to reestablish a long-term care facility in Highland, Illinois.

C) Section 1125.330 – Alternatives to the Project

The Applicant did not consider any other alternatives to the proposed project but provided a narrative in which the Applicant stated the proposed reopening of the long-term care facility as possible long-term options will provide dialysis treatments, an onsite infusion center, and respiratory and ventilator management services at the proposed facility.

VII. General Long-Term Care

A) Section 1125.530 - Planning Area Need

The applicant shall document that the number of beds to be established or added is necessary to serve the planning area's population, based on the following:

a) Bed Need Determination

1) The number of beds to be established for general LTC is in conformance with the projected bed need specified and reflected in the latest updates to the HFSRB Inventory.

2) The number of beds proposed shall meet or exceed the occupancy standard specified in Section 1125.210(c).

The proposed facility will be located in the Madison County Long Term Care Planning Area and Health Service Area XI. There is currently a calculated excess of 365 LTC beds in this planning area.

b) Service to Planning Area Residents

1) Applicants proposing to establish or add beds shall document that the primary purpose of the project will be to provide necessary LTC to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.

2) Applicants proposing to add beds to an existing general LTC service shall provide resident/patient origin information for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, applicants shall document that at least 50% of the projected resident volume will be from residents of the area.

3) Applicants proposing to expand an existing general LTC service shall submit resident/patient origin information by zip code, based upon the resident's/patient's legal residence (other than an LTC facility).

The Applicant has stated that the proposed nursing home will be in the former 76-bed *"***Faith Countryside Home"** and will serve the residents of Madison County. According to the Applicant the nursing home will provide care to the people of Highland where no one has to leave Highland and surrounding cities to receive long term care and rehabilitation. Based on the referral letters and waiting list that has been provided it appears that 50% of the projected admissions will come from the 17-mile geographical service area.

B) Section 1125.540 - Service Demand – Establishment of General Long-Term Care

a) The number of beds proposed to establish a new general long-term care service is necessary to accommodate the service demand experienced annually by the existing applicant facility over the latest two-year period, as evidenced by historical and projected referrals, or if the applicant proposes to establish a new LTC facility, the applicant shall submit projected referrals. The applicant shall document subsection (c) and subsection (d) or (e).

b) If the applicant is not an existing facility and proposes to establish a new general LTC facility, the applicant shall submit the **number of annual projected referrals, as required in subsection (d) or (e).**

c) Historical Referrals

If the applicant is an existing facility and is proposing to establish this category of service, the applicant shall document the number of referrals to other facilities, for each proposed category of service, for each of the latest two years. Documentation of the referrals shall include resident/patient origin by zip code; name and specialty of referring physician or identification of another referral source; and name and location of the recipient LTC facility.

d) Projected Referrals

An applicant proposing to establish a category of service or establish a new LTC facility shall submit the following:

1) Letters from referral sources (hospitals, physicians, social services, and others) that attest to total number of prospective residents (by zip code of residence) who have received care at existing LTC facilities located in the area during the 12-month period prior to submission of the application. Referral sources shall verify their projections and the methodology used.

2) An estimated number of prospective residents whom the referral sources will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the referral sources documented historical LTC caseload. The percentage of project referrals used to justify the proposed expansion cannot exceed the historical percentage of applicant market share, within a 24-month period after project completion.

3) Each referral letter shall contain the referral source's Chief Executive Officer's notarized signature, the typed or printed name of the referral source, and the referral source's address; and

4) Verification by the referral sources that the prospective resident referrals have not been used to support another pending or approved Certificate of Need (CON) application for the subject services.

The Applicant provided 15 referral letters documenting 1,926 residents to be referred annually to the proposed facility. The Applicant stated the facility would need 131 referrals annually to reach the 90% target occupancy assuming a 186-day average length of stay. Additionally, the Applicant provided a waiting list with 38 individuals currently on the waiting list. Based upon these referrals and waiting list there appears to be sufficient demand for the proposed services.

C) Section 1125.570 - Service Accessibility

The number of beds being established or added for each category of service is necessary to improve access for planning area residents.

a) Service Restrictions

The applicant shall document that **at least one** of the following factors exists in the planning area, as applicable:

1) The absence of the proposed service within the **planning area**.

2) Access limitations due to payor status of patients/residents, including, but not limited to, individuals with LTC coverage through Medicare, Medicaid, managed care, or charity care.

3) Restrictive admission policies of existing providers.

4) The area population and existing care system exhibit indicators of medical care problems, such as an average family income level below the State average poverty level, or designation by the Secretary of Health and Human Services as a Health Professional Shortage Area, a Medically Underserved Area, or a Medically Underserved Population.

5) For purposes of this Section 1125.570 only, all services within the established radii outlined in 77 Ill. Adm. Code 1100.510(d) meet or exceed the occupancy standard specified in Section 1125.210(c).

There are six facilities with 556 beds within the 17-mile GSA. Two-year average utilization of these 6 LTC facilities is 61%. Average Medicaid occupancy in these 6 LTC facilities is approximately 62%.

TABLE TWO

Facilities within the 17-mile GSA

					2-Year Average 2021 and 2022 (2)			
FACNAME	**Mile**	**CITY**	**Gen Beds**	**Star Rating (1)**	**Medicaid Days**	**Total Days**	**Medicaid Days % of Total Days**	**Bed Occupancy**
Highland Health Care Center	<1 mile	Highland	128	1	15,858	27,369	57.94%	58.58%
Aviston Countryside Manor	10.6	Trenton	97	1	10,089	21,023	47.99%	59.38%
Alhambra Rehab & Healthcare	15	Alhambra	84	4	4,053	13,895	29.17%	45.32%
Hitz Memorial Home	15.2	Alhambra	67	2	3,733	14,825	25.18%	60.62%
Clinton Manor	15.7	New Baden	90	5	24,672	27,749	88.91%	84.47%
Lebanon Care Center	16.6	Lebanon	90	1	16,518	17,931	92.12%	54.58%
Total			556		74,923	122,792	61.37%	60.49%

1. Star Rating from Medicare Compare Website
2. Medicaid Days and Total Days taken from Healthcare and Family Services Website for 2021 and 2022 and averaged

The service currently exists in this planning area; therefore, the Applicant cannot meet condition number one. No evidence has been provided that the existing facilities have access limitations due to payor status; therefore, condition number two cannot be met. No evidence of restrictive admission policies has been provided; therefore, condition number three cannot be met. No evidence of medical care problems has been identified by the Applicant, therefore condition four cannot be met. Two-year average utilization of these 6 LTC facilities is 61% therefore, condition number five cannot be met. As shown in the table above none of the facilities are at the target occupancy of 90%.

D) Section 1125.580 - Unnecessary Duplication/Maldistribution

a) The applicant shall document that the project will not result in an unnecessary duplication. The applicant shall provide the following information:

1) A list of all zip code areas that are located, in total or in part, within the established radii outlined in 77 Ill. Adm. Code 1100.510(d) of the project's site.

2) The total population of the identified zip code areas (based upon the most recent population numbers available for the State of Illinois); and

3) The names and locations of all existing or approved LTC facilities located within the established radii outlined in 77 Ill. Adm. Code 1100.510(d) of the project site that provide the categories of bed service that are proposed by the project.

b) The applicant shall document that the project will not result in maldistribution of services. Maldistribution exists when the identified area (within the planning area) has an excess supply of facilities, beds and services characterized by such factors as, but not limited to:

1) A ratio of beds to population that exceeds one and one-half times the State average.

2) Historical utilization (for the latest 12-month period prior to submission of the application) for existing facilities and services that is below the occupancy standard established pursuant to Section 1125.210(c); or

3) Insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above occupancy standards.

c) The applicant shall document that, within 24 months after project completion, the proposed project:

1) Will not lower the utilization of other area providers below the occupancy standards specified in Section 1125.210(c); and

2) Will not lower, to a further extent, the utilization of other area facilities that are currently (during the latest 12-month period) operating below the occupancy standards.

1. There are six facilities within the 17-mile GSA operating at 61% occupancy. Based upon that occupancy there are 216 LTC beds available for use in this 17-mile GSA.

2. There are 38 zip codes with approximately 241,450 residents residing in the 17-mile GSA. There are 556 LTC Beds within this 17-mile GSA or 1 LTC Bed for every 435 residents in this GSA. There are approximately 88,532 nursing care beds in the State of Illinois. There are approximately 12.62 million people in the State of Illinois or 1 LTC bed for every 143 residents. The ratio of beds to population does not exceed one and half times the State Average.

TABLE THREE
LTC Beds to Population

	Population	Beds	Ratio
State of Illinois	12,620,000	88,532	0.00704
17 Mile GSA	241,451	556	0.00231

3. The Applicant believes the proposed facility will not lower the utilization of other area facilities because no other facility in the 17-mile GSA offers in home dialysis service.

E) Section 1125.590 - Staffing Availability

The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that staffing requirements of licensure, certification and applicable accrediting agencies can be met. In addition, the applicant shall document that necessary staffing is available by providing letters of interest from prospective staff members, completed applications for employment, or a narrative explanation of how the proposed staffing will be achieved.

The Applicant provided a narrative as required and stated the proposed facility will create 50-60 jobs in the Highland Park community and according to the Applicant the supply of health care workers will not be an issue as the number of health care workers are more than the number of nursing LTC facilities in the area. The medical director will be Dr. Ahsan Usman. According to the Applicant staff will be hired once state licensure has been approved. The Applicant has met the requirements of this criterion.

F) Section 1125.600 - Bed Capacity

The maximum bed capacity of a general LTC facility is 250 beds, unless the applicant documents that a larger facility would provide personalization of patient/resident care and documents provision of quality care based on the experience of the applicant and compliance with IDPH's licensure standards (77 Ill. Adm. Code: Chapter I, Subchapter c (Long-Term Care Facilities)) over a two-year period.

The proposed facility will have a total 74 long term care beds, 14-beds dedicated to memory care, 50 skilled care beds and 10 intermediate care beds. The Applicant has met the requirements of this criterion.

G) 1125.610 - Community Related Functions

The applicant shall document cooperation with and the receipt of the endorsement of community groups in the town or municipality where the facility is or is proposed to be located, such as, but not limited to, social, economic, or governmental organizations or other concerned parties or groups. Documentation shall consist of copies of all letters of support from those organizations.

The Applicant provided community support letters from the Mayor of the City of Highland, the Highland Chamber of Commerce, City of Highland City Manager, City of Highland Economic Development Coordinator, Property Owner Gayle A. Fry, Tisha Flowers, Marketing Director Well Care Home NFP Inc., Susan Hulvey, Chief Operating Officer Well Care Home NFP Inc. The Applicant has successfully addressed this criterion.

H) Section 1125.620 - Project Size − Review Criterion

The applicant shall document that the amount of physical space proposed for the project is necessary and not excessive. The proposed gross square footage (GSF) cannot exceed the GSF standards of Appendix A, unless the additional GSF can be justified by documenting one of the following:

a) Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies.

b) The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix A.

c) The project involves the conversion of existing bed space that results in excess square footage.

The Applicant is proposing 74 LTC beds in 39,867 GSF of reviewable space or 539 DGSF per bed. The State Board Standard for LTC beds is 350-570 DGSF per Bed. The Applicant has met the requirement of this criterion.

I) Section 1125.630 - Zoning

The applicant shall document one of the following:

a) The property to be utilized has been zoned for the type of facility to be developed.

b) Zoning approval has been received; or

c) A variance in zoning for the project is to be sought.

The Applicant provided documentation from the City of Highland which states that the site of the proposed project is properly zoned for the project. Application for Permit page 94.

J) Section 1125.640 - Assurances

a) The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after the project completion, the applicant will achieve and maintain the occupancy standards specified in Section 1125.210(c) for each category of service involved in the proposal.

b) For beds that have been approved based upon representations for continuum of care (Section 1125.560(a)) or defined population (Section 1125.560(b)), the facility shall provide assurance that it will maintain admissions limitations as specified in those Sections for the life of the facility. To eliminate or modify the admissions limitations, prior approval of HFSRB will be required.

The Applicant has provided the necessary assurance that the proposed 74-bed facility will be at target occupancy of 90% within two years after project completion. The Applicant has met this requirement.

VIII. 77 IAC 1125.800 - Financial Viability and Economic Feasibility

A) Availability of Funds
B) Financial Viability

The Applicant is financing this project with cash of $3,490,000. The Applicant provided Deposit Account Summary from Chase Bank for Well Care Home NFP, INC. indicating that $600,000 was available to provide operating capital. Additionally, a personal financial statement was also provided for Dr. Usman. Based upon the information provided funds are available and the Applicant is financial viability. (See pages 96-111 of the Application for Permit)

TABLE FOUR
Amount Spent to Date

Land + Building	$2,350,000
Carpet replaced with vinyl floor	$200,000
Sprinkler Repair	$40,000
Fire alarm System Repair	$20,000
Fire Extinguishers Tagged	$5,000
Elevators Repairs	$10,000
Back-up Generator	$15,000
Plumbing repairs	$30,000
Rooms repairs	$89,000
Kitchen updates	$40,000
Exterior building repairs	$29,000
Dialysis Center Plumbing	$28,000
Electricity Bill Paid	$34,000
Total	$2,890,000

C) Reasonableness of Debt Financing
D) Terms of Debt Financing

There is no debt associated with this project.

E) Reasonableness of Project Costs

Modernization costs are $1,140,000 or $28.58 per GSF. The State Board Standard is $201.61 per GSF. This cost appears reasonable when compared to the State Board Standard.

Acquisition of Building and Property is $2,350,000. The State Board does not have a standard for this cost.

TABLE FIVE
Projected Operating Profit and Loss

Year	2024	2025	2026	2027	2028
Revenue	$4,560,150	$5,236,884	$5,636,887	$5,913,900	$6,199,738
Cost of Goods	$2,828,000	$3,184,000	$3,360,000	$3,456,000	$3,552,000
Gross Profit	$1,732,150	$2,052,884	$2,276,887	$2,457,900	$2,647,738
Salaries	$1,023,528	$1,083,650	$1,107,838	$1,132,586	$1,157,906
Marketing	$91,203	$104,738	$112,738	$118,278	$123,995
Admin	$60,000	$60,000	$60,000	$60,000	$60,000
Operations	$300,000	$300,000	$300,000	$300,000	$300,000
Other	$24,000	$24,000	$24,000	$24,000	$24,000
Housekeeping	$91,203	$104,738	$112,738	$118,278	$123,995
Total Operating Expenses	$1,589,934	$1,677,126	$1,717,314	$1,753,142	$1,789,896
Depreciation	$68,750	$68,750	$68,750	$68,750	$68,750
Interest Expense	$0	$0	$0	$0	$0
Operating Profit	$73,466	$307,008	$490,823	$636,008	$789,093

And thank you for your oversight.

MR. ROATE: Thank you.

Ms. Legrand?

MS. LEGRAND: I also vote yes based on the testimony.

MR. ROATE: Thank you.

Dr. Tanksley?

DR. TANKSLEY: Yes, based on the testimony.

MR. ROATE: Thank you.

Chairwoman Savage?

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

And thank you for getting that under control.

MR. ROATE: Thank you, Madam Chair.

That's seven votes in the affirmative and one vote for recusal.

CHAIRWOMAN SAVAGE: That is approved. Thank you.

Now we shall move on to applications subsequent to initial review.

So we will start with H-01, Well Care Home NFP in Highland, Illinois.

May I have a motion to approve

Item 23-042 for the establishment of long-term care home.

MEMBER LEGRAND: So moved.

MEMBER BUDDE: Second.

CHAIRWOMAN SAVAGE: Thank you.

Spell your name for the court reporter and we will get started.

DR. USMAN: Ahsan Usman, A-H-S-A-N U-S-M-A-N.

MS. ROMMERSKIRCHEN: Tanya Rommerskirchen, T-A-N-Y-A R-O-M-M-E-R-S-K-I-R-C-H-E-N.

MS. FORCE: Candace Force, C-A-N-D-A-C-E F-O-R-C-E.

(Witnesses duly sworn.)

CHAIRWOMAN SAVAGE: Thank you.

Mike, if you could give our state board staff report.

MR. CONSTANTINO: Thank you, Madam Chair.

The applicant proposed the 74-bed long-term care facility in Highland, Illinois at a cost of approximately $3.5 million. The expected completion date is September 30, 2024.

This project was deferred from the March 12, 2024, state board meeting. Additional information has been provided and excluded at the

end of this report, along with the transcript of the March state board meeting. State board staff finds it remain unchanged from the original state board staff report.

Thank you, Madam Chair.

CHAIRWOMAN SAVAGE: Thank you, Mike.

If you would like to proceed.

DR. USMAN: My name is Ahsan Usman. Good morning, Madam Chair, and all the board members, thank you for allowing us to come in front of the board.

We were here in March 12th, and I would like to apologize, I was not able to add additional information. During the process of application and I have submitted it, but I was not fair to do so. So I apologize for that inconvenience to the board. But we have added and submitted additional information.

I will just go over the project that we are here to invest in front of the board, and then I will mention what is our goal and what we want to achieve with this request.

Back in June '23 I purchased this shut-down, abandoned, vacant nursing home

building. It was built in 2004 and it had 74 state beds. And also, it has assisted living facility under the same roof at the same address. That assisted living facility has 36 apartment, and is up and running. We have license from the IDPH and we are operating assisted living in this area. So half of the building is assisted living and half is the nursing facility.

The building is already up to the codes and everything is fully furnished and ready to operate as a skilled nursing facility.

In approximately April, May 2021, this nursing home building got shut down due to their COVID situation and other stuff. I am not sure exactly what happened, but it was a sad day for the community when it was shut down.

Then I decide to purchase this one and reopen this facility and bring those 74 beds back to the community that they were there before, so I can continue to serve the community as the facility in that area and in Madison County. This building has like 60 state beds and 14 regular beds, and that is what we have applied for.

I myself, I am a nephrologist and I --

like, I do dialysis and medical record for a couple of dialysis centers in the area, and I have this goal in mind that the huge need for the skilled patients who have dialysis in this region. So my reason is to provide dialysis service on site and there are -- in miles and miles of radius, there is not even a single nursing home facility that offers dialysis on site. This will be the first one dialysis facility that will offer that, and I have submitted that in my application, that my plan is to serve that and provide that service to all the patients in the community.

This Madison County actually is attached close to like three counties and we will be able to serve, like, three adjoining counties.

Mr. Konig (phonetic), he is the manager, he was here back on March 12 when we came, and he came and spoke.

And everyone is in full support to open this facility. The main reason that I basically bought that building because they are the ones who mentioned the need for the community and they want absolutely this facility to come back to the community.

So precisely what we are trying to achieve here, we want to bring those 74 skilled beds back to the community, and we are not asking to build brand new facility, it's already built, established, operational building, and it was a nursing home before, and we are just using the same building, we are not building a new building.

So that is our goal, to serve the community for the need and dialysis on site.

MS. ROMMERSKIRCHEN: Thank you, everyone, for listening to us today. I just wanted to address. My name is Tanya Rommerskirchen, I am the CEO of Well Care.

The community has just opened their arms to us. We were expecting an open house of about 200 people, and we had approximately 500 people. And they are willing to just share that grandma and grandpa was here, mom and dad was here. They were excited to see this building come back to life. They felt like it was taken from them in the community and they are just welcoming it back.

I am a registered nurse and a long-term care administrator, and for many, many, many years I have watched the dialysis patients have to go

out in subzero temperatures and be gone five or six hours from their home.

This is their home and this opportunity just let's them stay in their own environment, the people that take care of them will be so much improved for them.

So I am very excited about this project and bringing this back to life. Thank you for your time.

MS. FORCE: I am Candace Force, director of business development.

So my thought is to go out to the hospitals and find out the needs for these patients, and we do have a waiting list. Currently, like he said, there's 14 memory care beds, so far we have nine on the waiting list for that. There is 60 skilled and long-term care beds, and so far we have 19 on the waiting list for that, and it is growing every day.

Last week alone we admitted five patients to Bria Nursing Home that actually live in Highland, they did not have a choice to stay in their hometown. So this is something that's very much needed in our community.

I appreciate you guys. Thank you.

CHAIRWOMAN SAVAGE: Thank you.

Do we have any questions from our board?

MEMBER BUDDE: Yes, a couple of questions.

What percentage of the patients do you anticipate will require the dialysis treatment?

DR. USMAN: I do believe that at least minimum like 15 to 20 patients, although 74 beds will be close to about 30, 35 percent need based on the area.

I live in the area, I live in the community, and I see that -- I am a practicing nephrologist also in Sangamon, the next county, and I see patients being discharged from the hospital all the time and they go -- unfortunately, they go to the nursing home, they don't provide dialysis, and then they have hardship for them to go to dialysis every day and in all the weather conditions.

I practice like two nephrologists and nurse practitioner, and in our practice alone we have 300 dialysis patients who are only seeing nephrologist. This is growing every day. The need for dialysis is growing every day.

So that was the idea, that why not we can serve the community better and bring this option to the table and serve them, and that's huge.

MEMBER BUDDE: Will you let other folks in the community that aren't residents get their dialysis service there? I don't know if that's legal.

DR. USMAN: No, we cannot because that's separate CON process for the dialysis, we cannot. We will be exclusively for the residents in the building.

MEMBER BUDDE: Okay. And my other question is just in general thoughts, the previous place couldn't make it, what is going to be different? Why is this going to be successful and sustainable financially?

DR. USMAN: If I tell you the truth, previous owner, they have $12 million loan, and I think they had some like -- because of the unexpected debt, and they were a not-for-profit and they did not get any support. I think that was the reason they went under.

In my situation, I have purchased the building and I have zero debt.

MEMBER BUDDE: Thank you.

MS. HENDRICKSON: You mentioned that part of it is that the dialysis will be offered to the residents only. Based on the application and the radius that you will be within, there's over 35, I think, long-term care facilities.

Can you explain to me why they have not -- you said none of them have dialysis, why they would not have already done this if the need was so great?

DR. USMAN: Basically, dialysis is a very sophisticated, very complicated-like service. Like, I understand, because I am a nephrologist, and it is very expensive, also.

So to build out the dialysis center in the building, it has a cost of over 12 hundred thousand dollars, and then my insurance and hiring staff to do dialysis, that is another 3, $400,000. Each machine is about 60 to $70,000.

So I think the lack of cost, which I believe is like a proof for the other people who are not familiar with dialysis, they don't understand all the mechanism of that. And then dialysis operators, other big companies, they are not interested in the nursing home setup, so they

do their standard on dialysis facility.

So I think there is a cost -- if I have to guess, is a cost to prevent people from bringing that service because it's very expensive to have it.

MEMBER HENDRICKSON: Just for clarification, on your project description that cost does not include the cost for the $3.49 million.

DR. USMAN: No, it does not, but like -- but we will have dialysis come there, like spend that money.

CHAIRWOMAN SAVAGE: Other questions by board members?

MEMBER KATZ: So what percentage, roughly, of the 74 beds do you expect to be commercially-insured patients?

MS. FORCE: We would like a percentage of about 50 percent of that, but we are going to try to get our beds -- we are going to try to get all of our beds certified from Medicare, Medicaid, and also insurance plans.

MEMBER KATZ: The reason I am asking is, I am trying to understand -- I completely understand the need for skilled patients and dialysis. I

also understand the economics of dialysis centers. My understanding is that most of the money is made on maybe all -- more than all of the money is made on commercial patients. And if you don't have a lot of -- I am struggling to see -- do you have enough commercial patients? And if you don't, it's great that you are doing this because the community needs it. But how are you going to pay for it?

DR. USMAN: Basically, the patients who are on dialysis, they need -- these are life-saving therapy, they need dialysis. So if they go to outpatient facility, Medicare, Medicaid, they pay for treatment, they pay about 900, $1,000 of treatment to the standalone alone dialysis treatment. But for the home dialysis therapy when you are doing on site at home, the Medicare and Medicaid, they pay around 250 treatment.

So every patient does not have to be commercial, they will be Medicare, Medicaid, and they will have treatment. And that's a huge push from the home therapy, because home therapy are far less expensive, like $250 versus outpatient.

MEMBER KATZ: So this is home hemo?

DR. USMAN: Yes, home hemo.

MEMBER KATZ: And a home hemo annual reimbursement --

DR. USMAN: Yes, they will separate.

MEMBER KATZ: -- is about what?

DR. USMAN: 250 per treatment. So if the patient is getting treatment at home on dialysis on site, the payments will be paying for that treatment.

MEMBER KATZ: I understand that, but my understanding is that the clinic hemo is about 300, plus or minus, about 42,000 a year, plus or minus.

So my question is if -- and the problem is that clinics can't make money if they did a hundred percent patients at $42,000 a year, they've got to throw in X percentage at three to four times that commercial payers are paying. If you don't have commercially-covered residents, how is this going to work financially?

DR. USMAN: That's a very good question and thank you for bringing that, because I understand, like, when we do dialysis in a home setting, like, the home setting and the outpatient setting, in

the outpatient setting, they can bill dialysis, they have to have big dialysis rooms, treatment areas, they have to have like -- like therapy, they have to have a lot of bio med, they have to have a lot of overhead of the facility, of the dialysis unit, like the rent.

I used to be joint partner with Avita (phonetic) and I was looking at all their expenses, so I know all the expenses.

When we do the onsite in the nursing home, we have a dedicated -- one small room that will just -- like, I have room, like we have six chairs. Already having done this, everything done, so my cost of that one room is not, because that is in the building already there and we are covered with all the communities, everything. So we have no extra expense to have that room.

And then on top of that, the machines -- home dialysis machine are totally different than the machines in the outpatient setting. So the machines that we have, we don't need any private room, we don't need any big, like, bio med people there. So those machines are self-sustained in the machine. So like making those machines is

very cost effective.

And then when we do dialysis in the room with staff, staff is a big expense. So one nurse and one technician in one room, they can watch like six people running on the machines, where in the dialysis units they have to have a lot of staff and technicians because they have to be like providing two, three people because they are spread out in the unit in one room. Staff is much less expensive.

MR. KATZ: So that makes sense. So if you have a hundred percent Medicare but if you had no commercial patients, you are saying you could make money, 250, for Medicare?

DR. USMAN: Hundred percent. My cost -- our treatment in the nursing home is $150 for treatment and we make $50 for treatment, $100.

MEMBER KATZ: One more question, just trying to understand. So when a patient needs dialysis and Medicare covers this, and then if you are not a Medicare-eligible person, Medicare covers everything, right, not just dialysis, everything?

DR. USMAN: That's right.

MEMBER KATZ: So is this kind of the back

doorway to flip your payer mix at the skilled nursing facility from Medicaid to Medicare? Is that kind of what's going on here?

DR. USMAN: No, no. You know, like we are -- basically the patients that are in the facility, they need dialysis, they are on dialysis. So that has not changed any.

MEMBER KATZ: Yes and no. Sorry to interrupt. Yes if the patient basis were static but no if you are in a skilled facility in the area that offers dialysis, people who just crash in the hospital and say I want to go to this facility because I can do it at home?

DR. USMAN: That is correct. Yes, that is correct.

MEMBER KATZ: So you will see a secondary tertiary boost in your Medicare mix?

DR. USMAN: Yes.

MEMBER KATZ: In the long run, that's the math.

DR. USMAN: You are absolutely right.

MEMBER KATZ: That's clever. Clever legal, but just clever. That's clever.

DR. USMAN: But we are providing --

MEMBER KATZ: I got it. I got it.

DR. USMAN: You are absolutely right.

MEMBER KATZ: Okay.

MS. HENDRICKSON: I have a follow-up question. First of all, thank you for your explanation. I think this is more directed to staff. Just for my clarity and understanding what I have in front of me today on the docket is related just to 74 beds. The dialysis information, while fascinating and very interesting, is not included in this conversation, correct?

DR. USMAN: That is correct.

MEMBER HENDRICKSON: I think that's where I am having the struggle. The uniqueness of your program, the need for it, is that next step, and I haven't had enough data to vet that impact of your next step to be attached to this in your market, right. So I think that's where my challenge is as an awareness. I feel like I am missing complimentary data on long term plus dialysis needs in that population. I am only looking at right now what you submitted from nursing-home-to-nursing-home.

I have nothing to comment on. I just want to make sure I understand that clearly.

MEMBER KATZ: So are we being asked to approve not the dialysis base, just the long-term care?

MR. CONSTANTINO: Just long-term care.

MEMBER KATZ: Do they need approval?

MR. CONSTANTINO: Yes. It's home care, it's considered home care. It's another section of IDPH.

MEMBER KATZ: So they have to go back to someone else to get that. Interesting.

MR. KNIERY: If they open it up to the public.

MEMBER KATZ: I understand.

I have to share the same concern. I am compelled by the -- but that's not really what we are voting on. I don't know how I feel about that.

DR. USMAN: Basically, we are, as Ms. Hendrickson mentioned, we are coming to the request to bring these 74-skilled beds back to where they were before two years ago. So they were on the inventory with the IDPH system, but those 74 beds fell off and we need those back up where they were before. That is

one point.

And the other point for like the dialysis, when I was asked by the board to submit the additional information on March 12th, I added in my addendum that my intention of rights of service, and that service does not require any CON approval, but that definitely requires IDPH survey to be done. That survey actually has been done on April 22nd. The IDPH team, because the dialysis is all done, it's up and like operational, but we cannot do anything until we get approval by the board today.

MS. HENDRICKSON: I just want to add I understand that. I think my struggle is the setting a precedence, right. I am approving based on not the dialysis, necessarily, and while you are demonstrating in your letter that there is an intent, you would also potentially, correct me if I am wrong, if we approve it, which is not to do it later on, correct, and that's my challenge right now.

CHAIRWOMAN SAVAGE: And then the question is, so you are saying that there is a need for these 74 beds, but when we look at the 17-mile GSA, most

of the nursing homes are at 50 percent, at best.

So how -- I mean, I know with dialysis it's probably more patients, residents, the previous nursing home as well, and then all these nursing homes for the most part are in the air, if need be. So how do you intend to get those 74 beds filled? Is it just going to be dialysis patients?

MS. FORCE: No. So scratch all the dialysis.

On the nursing home standpoint and long-term care, as I explained, we already have a waiting list and it's growing. One of our competitors, a nursing facility that is right next to us, we've already gotten five family members wanting to move their family members over for quality of care, as I explained earlier.

I also do (inaudible) which is 18 minutes from Highland. Last month -- or last week alone I admitted five patients that live in Highland that went to Bria. So there is definitely a need in this area.

We partner with all the hospitals, memory care. All the memory care around us is full. We have nine people on our waiting list with 14 beds,

and that's not counting the calls we get daily.

So there is definitely a need for the long-term Medicare and Medicaid.

CHAIRWOMAN SAVAGE: Are your assistant beds filled?

MS. FORCE: We already have eight, and we just did our grand opening, as she stated last month.

DR. USMAN: We just opened two weeks ago and we already have eight.

CHAIRWOMAN SAVAGE: We also have the issue with not having physician referrals to this. So how are you getting your referrals? Is it just friends and family themselves that are coming?

MS. FORCE: No. We use all types of platforms. So we use Care, which is a referral source. Plus, i partner with all the hospitals, so they send us referrals through Metro. We partner with at least 11 hospitals in our surrounding area that I go to weekly.

CHAIRWOMAN SAVAGE: Mike, did we get that data from the referrals?

MR. CONSTANTINO: No, we didn't get any referral. No, we did not.

CHAIRWOMAN SAVAGE: It wasn't required for

your CON.

MR. BEEDLE: My name is Dennis Beedle, I am a psychiatrist. Earlier in my career I worked at Michael Reese and they have a big dialysis program there. And it was interesting because being a dialysis patient is very difficult. I mean, it is not to be underestimated in terms of the challenges. Oftentimes, people do have comorbidities, there's a reason why they need dialysis. Most people will want to stay at home, and it is very clear I think that home-based -- what makes me very enthusiastic about this project in terms of looking at it from a patient perspective is that they will be receiving home-type dialysis which is, from a patient perspective, vastly preferred. Pump times are longer, generally you will have longer pump times than the commercial. Correct?

DR. USMAN: Yes. Yes.

MR. BEEDLE: The other thing for the board's consideration is people, after they've received outpatient dialysis in a traditional setting, oftentimes feel very sick, there's been massive fluid switches, and it is so much preferred to

have the home dialysis, not only is it cheaper, it is actually, I think, from at least a patient perspective, much preferred, people feel better afterwards.

So although there may not be -- you know, you kind of have to look at it as are you improving a better type of service delivery, not just, you know, the bed capacity, but are you actually enabling something that would really improve the quality of people's lives.

I am just seeing people feel much better after they've switched to the home dialysis. If I needed dialysis, I would much rather personally have it. And, yes, sending somebody out who's not feeling very well to a commercial center, you know, where there's outpatient centers, that's really hard. And if they feel sick afterwards, they have to hop back in the transport, go back to the nursing care facility.

So I was kind of excited about this model? I do think it's better. It's also similar to, like, the problems of finding a long-term care facility that will do TPN, you know, where there's definitely an increased number of people that need

that.

So I do think that should be considered that this is an innovative model. And I think in terms of the finances, if the applicant can pay cash for it --

MEMBER KATZ: I have a question. When you are talking about home, are you talking about home hemo?

MR. BEEDLE: Home hemo. I guess if I needed it, though, I would do home.

Back where I grew up, there's a neighbor who supported my mom, and he was having outpatient dialysis and then he got the home hemo. He said, I would have done this a really long time ago if I would have known how much better I would have been.

So I mean, I don't know if that's the general experience, but just on the basis of what I'm seeing consulting with people that have been on dialysis and also from experience, you know, people that struggle with these needs, you know, the home hemo most of it, as I understand it, although correct me if I am wrong, when you are doing a commercial outpatient dialysis, there is

time pressure, Medicare actually at some point reduced the pump time, so you have these massive --

MEMBER KATZ: You are jamming fluid in, it's three times a week, that's dialysis medicine.

MR. BEEDLE: Right.

MS. FORCE: So when they are going to these out clinics, not only do they have to wait for transportation to pick them up, it could be an hour, they could be late, they could not pick them up. They do go, they don't get fed while they're there, they don't get shaved while they're there, half the time they get infections.

So not only is this going to help the quality of life, this is going to help the rehospitalization rate tremendously.

CHAIRWOMAN SAVAGE: Other questions by board members? Dr. Tanksley?

MEMBER FOX: I have a question.

CHAIRWOMAN SAVAGE: Oh, okay. Go ahead.

MEMBER FOX: I am concerned, as noted in the application, for the lack of referral -- projected referrals, but what I am also hearing from the applicant is the unique feature to be able to take

care of dialysis patients.

Can the applicant tell us how many dialysis patients are anticipated in the 74-bed facility?

DR. USMAN: I anticipate about like 15 to 20 dialysis patients will be coming to the facility. And we have capacity to hold 24 dialysis patients as we speak right now.

CHAIRWOMAN SAVAGE: Dr. Tanksley?

DR. TANKSLEY: This has been a really good discussion about dialysis patients. I want to make sure, as one of my colleagues mentioned earlier and so that I am clear, the dialysis is not necessarily part of our decision, correct, that's another IDPH department. So I guess a question I have for the -- for the staff is, is that process of approval through IDPH, is that something that -- I guess I am getting confused.

Let me say I'm getting confused because it sounds like it's not, in that the applicant wants to move forward with a nursing home facility regardless if that is approved or not. I guess I am kind of confused, is that approved already for the dialysis or not?

MR. KNIERY: Dr. Tanksley, if I may, John Kniery, administrator for the board, and then I will ask Mike or George to chime in if I missed something.

As I understand this, you have the purview to add this to your consideration. I think the issue is all the numbers -- there hasn't been a market study, unfortunately. My background is long-term care.

I feel what you are doing, I understand what you are doing, but there's also on the board side, there's no need. So the documentation of that need is what we are missing and that's what I think we are hearing from the board members. I am not putting down your project at all, please don't take it that way, we are just looking for documentation of need, especially in light of Member Hendrickson said that facility went under, so why will you not?

One way is to do the market study, physician referrals, there are several things within our rules in that section, you know that.

I do commend you for providing your wait list, I think that's helpful. I think that's the

concern that I am hearing.

So to directly answer your question, Dr. Tanksley, yes, dialysis is something to consider, but you also have your criteria that precedes that.

MEMBER KATZ: Question for John. The data suggests there's not a need, they have a long waiting list. So which is it? Is it just a temporary waiting list? Is the data wrong? Or are they just providing better product? I don't see another option.

If the answer is the data is wrong, okay, if the answer is in the next six months they are not going to have a waiting list. If the answer is they are providing a better product, people have a choice wanting to go there, why wouldn't we approve that?

MR. KNIERY: I would say if you are getting referrals, bring in your referrals if you're getting referrals.

MS. FORCE: I did not know that was something I needed to provide to you guys, but they are not really technically sending us referrals until they are open, they are not going to. Why would they

send us a referral for us to say we are not open? Yes, they want to come to our area, but we are not open.

So last week alone five people from Highland went to Bria Nursing Home, so they are there for a short-term rehab and want to go back to Highland. I have a waiting list of seven people that are in Bria Nursing Home right now that want to move to Highland because that's where they are from. That's in the 19 that are on our waiting list. So we are going to get referrals, they're there, it's just why would they send us something when we are not open.

MR. KNIERY: I mean, this is something, you know, we always got referral letters before a project was open. You guys are ahead of the schedule that you have a facility. It's not a stretch to ask a provider and hospital.

MS. FORCE: I can get that, that's not a problem. We can definitely get that.

DR. USMAN: And if I may add, they definitely do have a need every day. But if we look at the project that we have the building itself, I don't know if someone has pictures of the application,

the building is so beautiful, it's a gorgeous brand new building. It has -- the normal regular nursing homes, they have like four residents sharing one small bathroom, and in this facility it's every room is either private or semi-private, and only maximum two people will share one handicap bathroom. So it is so neat, clean, brand new facility and it's kept so beautiful.

Like, the quality of care is so amazing that none of the nursing homes in the whole State of Illinois can compete with this facility. I am not talking about medical, I am talking about the whole State of Illinois, not such a beautiful a building anywhere that you can find in this facility anywhere.

So the quality of the building itself is so beautiful and it is not only acceptable in the building, they will be even very high-tech, in my opinion, where they can, like, have back quality of life.

MEMBER KATZ: So you just answered the question. Let me ask you a question from the staff. When we talk about market capacity and market demand, do we control for better? Is it

our job to say when a better project comes on, it should not force a lesser project off the market?

MR. KNIERY: I don't want to comment on that. I am aware of what it is in that area.

MEMBER KATZ: Okay, fair enough.

MS. DOMINGUEZ: I don't see your question about this data being wrong or anything. It's not that the staff was incorrect, it's that there wasn't information to feed into that criteria. The applicant has indicated they have produced a referral, it was in the application since March, and the findings in the staff reports since March that that information was missing, they didn't introduce it.

MEMBER KATZ: The referral letters are not the numbers of beds.

MS. DOMINGUEZ: No. No.

MEMBER KATZ: My sense is referral letters are meant to say when a new facility comes on line, will there be a demand. If you believe their wait list numbers, I am not sure why we need referral letters. If this is just a check-the-box exercise, we can do that. We have all we need.

When I talk about the data, I am talking

about the number of beds in the serving area, I'm probably using my terms wrong, but you are missing this.

MR. KNIERY: The wait list is 19, right?

MS. FORCE: Nineteen for the long term and nine for the memory care. So that's nine out of 14 and 19 out of 60. I mean, if we wanted to just make up numbers, we can throw those numbers way high and the numbers that I am getting calls per day.

MEMBER KATZ: And the referral letters that we would want is doctors, hospitals, district planners in the area. If they were open, we could accept them, and we are going to make a decision based on those that are valuable. That's what the rules call for, is it valuable.

MR. KNIERY: The rules are there for a couple of reasons. They are there -- we've seen so many like Highland close. There's been so many that have closed. I think as in the market study, if they are done honestly, they are done right, because we are having these applicants spend money, typically they haven't already bought the facility or built the facility, so it's a little

bit unique, which is fine, but we are asking -- we are trying to give them the best footing, this isn't a certificate of want, it's a certificate of need, we have to show a document.

MEMBER KATZ: Right, but it's not a full government -- it's the intersection of public (inaudible) and for-profit enterprise.

MR. KNIERY: Right. Right.

MEMBER KATZ: It's interesting.

CHAIRWOMAN SAVAGE: Anyone have any other questions?

MR. BEEDLE: At this point if the applicant wanted -- this is kind of a procedural question. If the applicant -- before the vote, the applicant decided that they wanted to have an extension to get letters from referral sources and then come back with that initial information, would that be something they could request?

MR. KNIERY: That is something they could request. This is their first initial consideration, if they should for some reason pursue the intent to deny, which is just that, intent to deny this is not a final deny, this is the first consideration for this applicant.

MR. BEEDLE: Okay.

MS. DOMINGUEZ: They would then be able to present this data once again and then have you do another vote.

MR. BEEDLE: I am not a voting member.

MS. DOMINGUEZ: I understand, but just to advocate everyone else, it's not completely turned down, it's just another opportunity. They have options, one of which would be to provide this additional data for a reconsideration by the board and then there would be another vote on it.

MEMBER HENDRICKSON: Just follow up, if there was an intent to deny, how soon could they bring back or be reconsidered?

MS. DOMINGUEZ: It would depend on the submission of the data. Typically, it would be in the next meeting. However, if there is data that staff would need to review again, there is, by the statutes and the rules, there is a set 60-day period for the staff to review it, so that would be taken into consideration.

CHAIRWOMAN SAVAGE: That would depend on how soon they got the information in order to review it, depending on whether the case is on for

June 25th is the next meeting.

Other questions?

MEMBER KAATZ: Maybe its a more of a comment. As far as the long-term care -- let me back up.

I think I understand what you are attempting to do clinically, and I applaud you for your innovation, okay, but from a numbers standpoint, I'm totally confused about estimating market demand for your long-term care beds.

Could you think about getting together with the staff? I believe that's allowable, right.

CHAIRWOMAN SAVAGE: Yes.

MEMBER KAATZ: And if you could come back somehow with one consensus well-thought out expression market demand, that would really help me, because I am comfortable with everything else but I am uncomfortable, looking at the staff report really pronounced excess duplication and utilization, and if you can come back and straighten that out with one common denominator, that would help me a lot. Thank you.

MS. FORCE: Okay.

CHAIRWOMAN SAVAGE: Are there questions?

Go ahead.

DR. USMAN: Am I allowed to ask question or no?

MS. DOMINGUEZ: It depends. A question of the board?

DR. USMAN: Yes.

MS. DOMINGUEZ: As far as the procedure goes?

DR. USMAN: Not the procedure.

MS. DOMINGUEZ: I think if it's an explanation of the topic here, I think that would be appropriate, but I think if it's a question that relates to other requests that you may provide new information on, I think it might be better to do that on the side after you ask for a referral or there's a vote and you receive whatever decision. So I will leave it up to your criteria. If it's something related to the data, if there is a question like that, but if you have just a bigger general procedural question, I think it would be more appropriate to do that offline.

DR. USMAN: Related to data.

MS. DOMINGUEZ: But data that you've already submitted?

DR. USMAN: Yes, submitted and the request to

be broader.

MS. DOMINGUEZ: I am not sure what kind of question.

CHAIRWOMAN SAVAGE: Is this the March 12th data you put in your letter?

DR. USMAN: The whole application. That is not a problem.

CHAIRWOMAN SAVAGE: Go ahead.

DR. USMAN: Basically, the way I think and believe, I will definitely do whatever the board asks us to do, there's no question about that. The question is, we are requesting those 74 beds to bring back to the community, which were there, and allowing this building at that location for the same purpose, why cannot be reinstated as it was two years ago? That's my question. Why do we need to create new data, new referral, new everything, when this is existing established nursing home and performed for 20 years before they closed? Now three years later we are asking why do we have to go over all again for the same building, the same thing when we are not requesting to bring in new beds?

MR. KNIERY: That license was relinquished,

okay, so the need is totally different. Your need is your need, it's not their need.

And on top of that, they may have addressed the need that was needed at the time, the demographics have changed. That's the whole point for the new criteria, what are the demographics today.

Again, I think market study provide that you have the long term elderly population in the area, you know, by age. I mean, there's so many different factors. That's why there is a different criteria there.

MS. DOMINGUEZ: It's not technically a reinstatement. As John indicated, you are a new owner, for lack of a better word, provider, new company that is going to be providing. So maybe that would technically be a reinstatement, but you are not.

So a new license with that application comes consideration of all the factors that are in the rules, in the statutes that are required to be part of the consideration.

There is no -- you know, each member decides how they weigh the factors, how they

consider what data they would believe is relevant or not when they make their decision, right, but it's your job to present this board with a new application.

We understand that the beds were there before, but you are a new applicant and that's why you are being requested to present this information for your facility, not the previous one, and I don't think you would want to.

MR. BEEDLE: If I understand, I am new to the board, but my understanding is there's also a response, there is a surplus capacity of long-term care license beds and it is felt that that excessive capacity can drive up cost.

So one of the responsibilities of the board, as I understand it, is to make sure that there's not too many of anything, you know, that would essentially drive up costs.

So even if it's a superior product or approach, you know, there is this counter balancing, you know, capacity. So that's my understanding.

So if someone poses that it's not automatic that we should not approve, you know, or

the board should approve, it doesn't mean it was really the thing with that particular nursing home closed, right.

CHAIRWOMAN SAVAGE: At that time that's when we re-evaluated the criteria of those areas, when one comes in and one closes down. What's going on in that area at that time. What is the need. Because there's so many excess beds at the facility, whether we talk about quality, of course quality is important for healthcare people, but in all these other places that have closed down, you know, that might not be good, it might not be enough nursing home beds in that area, and then the cost may be driven up in a facility, something of that nature. So that's why we look at that time.

Like we said, if you continue and bought it before they sold or went under then, then that would be different, but if they are new, then you have to start over.

MR. BEEDLE: Does that answer your question?

DR. USMAN: Yes.

MR. BEEDLE: It's kind of a funny thing, you know, there's a regulatory frame that is supposed

to help make sure that there's not excessive capacity.

Like new services fit into that, I am very excited about the idea that people won't have to be, you know, transported to an outpatient dialysis center where they are going to get a quick, you know, dialysis run, feel sick and go back. I think it's a very innovative model.

CHAIRWOMAN SAVAGE: Other questions or comments?

MEMBER LEGRAND: So you did say you were going to the area hospitals to speak to them?

MS. FORCE: Yes, correct, I spoke with all the presidents of the hospitals, I work with all the social workers at every hospital every day, and I guess that we do get referrals daily, but we are placing them in Bria because we are not open in Highland.

CHAIRWOMAN SAVAGE: Other questions? Okay.

George, if you could call the roll.

MR. ROATE: Thank you, Madam Chair.

Motion made by Ms. Legrand, seconded by Mr. Budde.

Mr. Budde?

MEMBER BUDDE: I think you've got an interesting idea and obviously, Doctor, you can make A $2.3 million bet on this, but I am concerned about you need to tighten up the application a little bit for this data, and I am sure the letters feel like a formality, but I have to respect the staff's work and strongly suggest -- I am going to vote no with the hope that you would work with the staff and tighten up the data and formalize the conversations, you know, with the hospital CEOs and what have you in the region.

MR. ROATE: Thank you.

Mr. Fox?

MEMBER FOX: I will vote no because of the excess bed inventory. Although the applicant has provided some interesting and potentially counter reasons for why the board should approve this project, I don't feel comfortable yet with the referrals that have been outlined.

MR. ROATE: Thank you.

Ms. Hendrickson?

MEMBER HENDRICKSON: I also vote no similar to Mr. Fox, it's a very compelling need, but based on

what I have available to validate against, it's missing some information, so I am voting no to that.

MR. ROATE: Thank you.

David Katz?

MEMBER KATZ: I am going to go off the board here and vote yes, actually enthusiastically, and I will offer my thoughts. One is, it does sound like the rules would say that we vote no because there's not enough demonstrated in the math, there's not enough referral letters. And if we were just up here doing what -- exactly what is supposed to happen, I'm not sure we would be up here, we'd be doing this by computer.

So in the spirit of not being an automaton and also being respectful of staff's work, I am going to try to use some judgment here, and my judgment, right or wrong, is that this is better medicine, and it may only be for 20 dialysis patients or 15 dialysis patients at a time, but it's a better -- home hemo is better care.

And, you know, I think what's going on here, put aside the capacity supply and demand,

it's just a better product and I think what the doctor has outlined there is a creative model that you've come up with, which I think is going to -- you know, some facilities have struggled to be profitable, and there's a lot of reasons for it, and this is an approach that actually flips a bunch of Medicaid patients to Medicare, which directly impact the P&L of the facility and will also save the state money and it will probably save the federal government money, because a home hemo patient is less than a clinic hemo patient.

And so, I am going to vote to approve it. I know I am going to be outvoted here, but I am going to vote to approve it.

And I guess I would ask the staff, you are not -- I mean, the onus is going to be put on the applicant more than staff. I would also ask the staff to work with the applicant to figure out the supply and demand need or not need, because I would say that if we look back, because I anticipate what will happen, the applicant will come back and, unfortunately, come back and get referral letters, and we will demonstrate the need, per the rules, and we will vote yes and we

won't really know anything more about it.

The only for sure is that this group of 12 people will only spend another half hour, an hour, so that will be another 12 hours of time spent, that we already said in March.

In hindsight, we are going to look back and we are going to say there was demand or there wasn't demand, and it would be really nice to have a view on that today because if the answer is our math is wrong, there are different issues, whether they submitted the referral letters is not the same as to whether the bed count is the same.

If we can say now that's -- that the way we are doing it doesn't reflect the market, then let's change it, and if we say no, our analysis is right, then why are we even debating this now? Because to me, if they didn't meet the rules, then why does it come up for a vote?

Sorry about the editorial, but I am enthusiastic in my support of what you are doing. It sounds like you are up against the wall today, but I am supportive.

MR. ROATE: Thank you.

Gary Kaatz?

MEMBER KAATZ: I admire your creativity in medicine, I think you've got a great idea. I am going to vote no because you need to tighten up the demand for me. I am really concerned, and the board's -- one of the board's primary missions is to really monitor costs, bring in capital costs, and I think in that vein I really need to see more evidence about what the market demand is like, but I do applaud you for your creativity.

DR. USMAN: Thank you.

MR. ROATE: Thank you.

Ms. Legrand?

MEMBER LEGRAND: After listening to Mr. Katz, I really like everything, I know where Highland is and I know the area well, I understand the need desperately. I also know that I am here to say what our staff has done in COVID centers is unique for beds and that stuff, but I am conflicted which way to vote.

I really want to vote yes, but since I am here to say what you actually brought before us, you didn't bring us any letters or anything like that, I am going to have to say no along with the rest of the board, but I do want you to come back

with those letters, work with the staff, get us all that information, because the people need it. There is a lot of -- where I live, the town I live in, which is not too far from Highland, there are a lot of dialysis centers there, it is needed. Please come back to us so we can all say yes.

MR. ROATE: Thank you.

Dr. Tanksley?

DR. TANKSLEY: I am going to vote no based on the explanation that I was given regarding our jurisdiction as a board, it sounds like, and by the state staff report, that there's 365 excess beds in this area. If I am understanding correctly, that I am tasked with -- this particular board is tasked with voting on the long-term care and yet there seems to be a need for that, I am voting no.

I agree with one of the members on the board that talked to the necessity and the innovation of this model as a hemodialysis, you know, as a dialysis within a long-term care, I think that's exceptional and there is most likely a need for that, but from what I can understand, that is not our jurisdiction to vote on that

dialysis component.

So I would say it might be beneficial to work with the state board more on which approval to converse, to have to do with coming with the -- you know, the dialysis approval already that may say, well, of course, you should put it inside a long-term care facility.

I don't know how that works, I am going to be honest, but I will say based on what we are able to vote on today, that I am going to vote no, but it's a reluctant no, I think it's a very creative idea and it could be beneficial and there's probably a need, but the I would have to say you guys need to show that need.

So thank you.

MR. ROATE: Thank you.

Chairwoman Savage?

CHAIRWOMAN SAVAGE: So in-home dialysis, I believe that sounds like it's much needed in that area, and this a very innovative model, so I applaud you on that, bringing that into long-term care, but I vote no based on insufficiency in meeting our board rules that we have to hold all applicants to.

I would like to see in future vote sufficient referral based on our board rules and strongly suggest working with our staff and see a consultant to tighten the application and to address the areas that have not been met when you return.

MR. ROATE: Thank you, Madam Chair.

That's one vote in the affirmative, seven votes in the negative.

CHAIRWOMAN SAVAGE: So that motion of intent is denied. The staff will be in touch with you and we hope that you will be in touch with them.

Take care.

DR. USMAN: Thank you.

THE COURT: Next up is going to be H-02 -- does anyone need a break?

(Break.)

CHAIRWOMAN SAVAGE: We are going to get back in business.

So now we are, let's see, as I said, H-02 Advocate Outpatient Center, Westmont, Illinois.

May I have a motion to approve by the board 24-001 for the establishment of a medical office building.

23-042 Well Care Home NFP - Highland